BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: Lu-Wei King, M.D. Physician's and Surgeon's Certificate No. A 50695 Respondent.	Case No. 800-2019-055503

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on February 16, 2023.

IT IS SO ORDERED January 17, 2023.

MEDICAL BOARD OF CALIFORNIA

Laurie Rose Lubiano, J.D., Chair
Panel A

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LU-WEI KING, M.D., Respondent

Case No. 800-2019-055503

OAH No. 2021110136

PROPOSED DECISION

Mary Agnes Matyszewski, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter by videoconference and telephone on August 22, 23, 24, and 25, 2022.

Keith Shaw, Deputy Attorney General, Department of Justice, State of California, represented complainant, William Prasifka, Executive Director, Medical Board of California, Department of Consumer Affairs, State of California.

Raymond McMahon, Attorney at Law, Doyle, Schafer, McMahon, represented respondent, Lu-Wei King, M.D., who was present.

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on August 25, 2022. As discussed with the parties, personal identifying information was redacted from the documents post-hearing.

PROTECTIVE ORDER SEALING CONFIDENTIAL RECORDS

Exhibits 9 and 11, medical records, were received and contained confidential information. It is impractical to redact the information from these exhibits. To protect the privacy and the confidential personal information from inappropriate disclosure, those exhibits are ordered sealed. This sealing order governs the release of documents to the public. A reviewing court, parties to this matter, their attorneys, and a government agency decision maker or designee under Government Code section 11517, may review the documents subject to this order, provided that the documents are protected from release to the public.

SUMMARY

Complainant alleged that Dr. King, an OB/GYN, committed gross negligence and was repeatedly negligent during his 2016 post-operative care and treatment of a patient who delivered twins by Cesarean-section (C-Section) and later died, as well as for his prenatal and post-delivery documentation. Complainant also alleged that Dr. King failed to maintain an active and current fictitious name permit (FNP) at two of his medical offices.

Complainant failed to prove those allegations by clear and convincing evidence. Moreover, the allegations were based on complainant's expert's inaccurate recounting of the facts. When the actual facts were considered, there was no showing, let alone a clear and convincing one, that Dr. King violated the standard of care during his treatment or in his documentation . Further, no clear and convincing evidence established any FNP violations.

Based upon this record, the first amended accusation is dismissed.

FACTUAL FINDINGS

Jurisdiction

1. The board issued Physician and Surgeon's Certificate No. A 50695 to Dr. King on April 28, 1992. That certificate was in full force and effect at all times herein and will expire on December 31, 2023, unless renewed. There is no history of discipline against Dr. King's medical license.

2. The first amended accusation was signed by complainant in his official capacity on May 31, 2022. Complainant alleged Dr. King violated Business and Professions Code sections 2227, 2234, 2266, 2285, and 2415 when he committed gross negligence (First Cause for Discipline), repeated negligent acts (Second Cause for Discipline), failed to maintain adequate and accurate medical records (Third Cause for Discipline), based on Dr. King's 2016 care and treatment of a patient who delivered twins and later suffered uncontrolled bleeding from which she died. Complainant further alleged that Dr. King failed to maintain active and accurate fictitious name permits (FNPs) at two of his clinics (Fourth Cause for Discipline.) Complainant also sought cost recovery.

3. Dr. King filed a notice of defense to the original accusation, requesting a hearing. The Government Code does not require that respondent file an amended notice of defense, and this hearing ensued.

Dr. King's Education, Experience, and Employment History

4. Dr. King testified about his education, training, and experience, which were also set forth in his curriculum vitae (CV). He has been practicing in the High Desert since 1994 and been a board-certified OB/GYN since 1997, recertifying yearly since that time. He is also a Fellow of the American College of Obstetricians and Gynecologists (ACOG). He has privileges at several hospitals, which are geographically spread quite far apart, and serves in leadership roles on numerous committees. He was the Department Chair of the Maternal Health unit for 12 years and is now the Vice Chair, where he also served on the Medical Ethics Committee. In that role, he oversaw practitioner performances at the hospital. He has served as the Chief of Surgery for several years.

He was the youngest physician when he arrived in 1994 and is one of seven OB/GYN's practicing in the Victor Valley geographic area. In the 20 years he has been in this community, they have had trouble finding other OB/GYNs to join them, and trouble recruiting physicians of all specialties, as well as nursing and other staff. In the High Desert there simply is not enough staff to meet patient needs, and the situation is not improving. As a result of this patient's death, Dr. King created a laborist program at Victor Valley where he fills more than half of the shifts because there simply are not enough OB/GYN's.

Care and Treatment of the Patient

5. The information set forth below was derived from the medical records, the deposition testimony of Dr. King and the nurses and doctors involved in the patient's care that was obtained during the civil litigation, Dr. King's summary of care

provided to complainant, the statements Dr. King made to the investigator and the medical consultant during his interview, and Dr. King's testimony at this hearing.

HIGH DESERT WOMEN'S MEMORIAL MEDICAL CENTER

6. Dr. King uses an electronic medical record (EMR) system in his office. He explained the numerous issues he and his colleagues have had with the system, including the inability of the system to create just one visit entry if twins are in different positions. Instead, the system creates a second visit entry, making it appear as though the patient was seen twice. Dr. King also explained how the dates reflected in the records can be the dates the records are printed, not the dates of the visits. For example, the first page of the patient's records has a date of December 19, 2017, which is more than one year after the patient died, and 16 months after Dr. King last saw the patient in his office. This page also lists the patient as being 41 years old, which she would have been had she been alive on that date.

Dr. King's only explanation was that this must have been the date the record was printed and because the patient's age was recorded at the first visit, the EMR automatically updated her age when the record was printed because it does not know the patient died. Dr. King's explanation made sense given that this date was on what appeared to be the face sheet of the records, and the information contained therein could only have been obtained during the actual office visits, which were clearly identified in the records. Dr. King's testimony regarding his records and the EMR was credible and unrefuted.

7. The patient had an initial physical examination on June 20, 2016, the findings of which were documented in the records. In the comments section Dr. King noted the patient was 40 years old, gravida six, para five (six pregnancies, five live

births), and was here for her initial prenatal visit. The patient's last menses was January 10, 2016. She had a "late entry to prenatal care." Dr. King referred her to an OB/GYN specialist because of her advanced maternal age and twin gestation. All other parts of her physical examination were within normal limits. Many portions of the record regarding the patient's medical and patient history were blank. Dr. King testified that he requested the medical records from the patient's prior treating OB/GYN and intended to insert that information in the records when he obtained those records.

8. The two entries dated June 20, 2016, contained all the same information except for the fetus presentation and fetal heart rate. The patient's "best estimated" weeks of gestation was 22.40 and her fundal height was 38 cm. One twin was vertex with a fetal heart rate of 152, the other twin was transverse-back with a fetal heart rate of 136. Dr. King explained that the EMR created these two entries because of the difference in the fetuses' presentation and heart rates. In the Comments section, one entry on June 20, 2016, stated: "See progress notes: Twin A"; the other entry stated: "See progress notes: Twin B transverse." The chart contained patient education records referencing the information and counseling the patient was given at this visit. The patient was to be seen in four weeks.

9. In the Progress Notes on June 20, 2016, Dr. King typed (errors in original):

> Pt's here for her initial prenatal visits now at 22 weeks of gestation Twins. She was previously a pt of [name of prior OB/GYN] and now transferred to our Services. Pt's is a 40 y/o G6P5 as referred to [specialist] due to [advanced maternal age] and twin gestation. All other prenatal record are being requested from [prior OB/GYN]'s office. Next

appointment in 4 weeks. Discussed with the patient about C section vs Normal delivery of the twin. Patient op to have C section. The risk of C section is alos explaint.

10. Although she was supposed to return in four weeks, the patient was next seen three months later on September 7, 2016. Her "best estimated" weeks of gestation was 33.60 and her fundal height was 34 cm. Because both twins were vertex with fetal heart rates of 140, the EMR only created one entry for this visit. The Comments section stated: "see progress note." The chart contained patient education records referencing the information and counseling the patient was given at this visit.

11. In the September 7, 2016, Progress Notes Dr. King typed (errors in original):

> S-pt seen c/o of a lot of pressure, no bleeding Ovital stable cervix. closed A: 33 weeks IUP twin, not compliant to prenatal care she has been missingprenatal care more than two months, she claimed there was domestic problem and transportation problem P: two weeks, advise patint to keep next appoint otherwise has to drop her as patient. She said she will keep her visit., advise go to labor and delivery if bleeding, leaking or contractions three in 10 min.

VICTOR VALLEY GLOBAL MEDICAL CENTER RECORDS

September 11, 2016, Treatment

12. The patient was admitted to Victor Valley Global Medical Center (Victor Valley) on Sunday, September 11, 2016, at 8:43 p.m.

13. The Obstetrics Admitting Record, completed by the admitting nurse at 9:03 p.m., documented that the onset of labor began at 6:00 p.m. The patient was 34 weeks pregnant, gravida six, para five, and an expected due date of October 22, 2016. The reason for admission was a primary C-section because she was carrying twins and was in preterm labor. The patient denied medical complications and her obstetrical complications were noted as "twin PTL." The patient's pain was a 7/10 and the type was "cramping." The frequency of her contractions were one every ten minutes with a "duration of 130" and moderate intensity. Her membranes were intact, there was no vaginal bleeding, her station was -1, her effacement was 90, her dilation was 7 cm, and the presentation was vertex. The Physical Assessment documented a blood pressure of 134/76 with a pulse of 93. No prenatal records were available on admission, but the patient had undergone regular prenatal care. (As noted in Dr. King's records, this statement by the patient was not true as she had been non-compliant with her prenatal care.) The patient's general health was listed as "healthy," and she denied various illnesses and conditions. Her plan for birth was spinal anesthesia.

14. Dr. King performed a physical examination which he documented on the History and Physical Form he completed at 9:00 p.m. The patient's chief complaint was lower abdominal pain. He wrote that she was 32 weeks gravida six para five, and the plan was to perform a C-section.

15. Dr. King ordered an ultrasound to determine the fetal presentation. The ultrasound was performed at 9:04 p.m. and indicated that both fetuses were cephalic.

16. The Twin Obstetric OB Limited Worksheet documented that the patient's last menstrual period was "unknown" and her gestational age by last menstrual period was "___." (A line was drawn in the space indicating this information was unknown.) She had had no previous studies performed at Victor Valley.

17. On September 11, 2016, at 9:30 p.m., the patient signed an informed consent acknowledging that Dr. King ordered a transfusion or possible transfusion of blood or blood products and that she was advised of the possible risk of developing hepatitis, AIDS, or other complications as a result of the transfusion. (Although not alleged, while testifying, complainant's expert implied that Dr. King had not obtained an informed consent for a blood transfusion, but this document belied that claim.) The records also contained the numerous other informed consents the patient and/or her representative signed.

18. The September 11, 2016, Labor and Delivery Nutritional Screening/Evaluation Notes documented the patient was at 34 weeks gestation. She complained of abdominal cramping.

19. Labor progress notes, completed by a nurse, documented discussions with the patient regarding the C-section, orders given by Dr. King, including medications to slow labor and to assist the twins given an impending premature delivery. Notifications were given to another hospital's neonatal intensive care unit (NICU) and the house supervisor. At 9:00 p.m. the patient was dilated to 6-7 cm with -1 station. Dr. King notified the operating room (OR) regarding the impending delivery at 9:10 p.m. At 9:15 p.m. the patient's blood pressure was 137/76 with a pulse of 93. At 9:30 p.m. she was dilated to 9 cm with +1 station. Her blood pressure at 9:45 p.m. was 147/82 with a pulse of 90. At 9:55 p.m. the nurse wrote: "Dr. King called. Stated take patient OR stat. CFM x2 removed." The nurse wrote at 10:02 PM: "Patient transferred OR via L and D bed, stable & undelivered. Respiratory therapy called & notified."

20. A September 11, 2016, Pre-Anesthetic Nursing Admission Assessment completed at 9:30 p.m., recorded the patient's blood pressure as 131/81, with a pulse

of 88. Her current problem was preterm labor, and the physicians explained the risks of surgery and blood transfusion to her.

21. Blood drawn at 9:40 p.m. indicated that the patient's hemoglobin was low at 9.1 (normal range is 12.0-16.0), and her hematocrit was low at 28.9 (normal range is 37.0-47.0).

22. On September 11, 2016, at 10:38 p.m., Dr. King dictated his Operative Report documenting the low transverse C-section he performed using spinal anesthesia. Dr. King's preoperative diagnoses were pregnancy at 32 weeks with twin pregnancy and cervix dilated to 6 cm on admission; both twins in vertex position on admission. His postoperative diagnoses were the same except there was a third diagnosis that the second twin was in the transverse position. The patient's estimated blood loss was 500 mL. Dr. King's "Operative Findings" included: "Low transverse cesarean section delayed with two premature baby boys, Apgar score of 9 and 9." He documented the position of the twins, that the patient's tubes and ovaries were grossly normal to inspection, she tolerated the procedure well, and was sent to the recovery room in stable condition. His report also contained a section titled "Procedure in Detail" wherein Dr. King documented the specifics of the procedure. Dr. King electronically authenticated this report on October 6, 2016, at 6:03 p.m.

23. A September 11, 2016, document labeled "Post-Operative Orders for Dr. T. King" noted the orders given by Dr. King post C-section.

24. The September 11, 2016, Anesthesia Record completed by the anesthesiologist documented the spinal epidural performed and the medication administered during the C-section, including the Methergine administered. (Methergine is given postpartum to help stop uterine bleeding.) Anesthesia began at

9:45 p.m. and ended at 11:05 p.m. The patient's pre-induction blood pressure was 131/81 with a pulse of 91, and her post-anesthesia blood pressure was 104/97 with a pulse of 89.

25. The Medication Administration record (MAR) documented the administration of various medications to the patient, including the administration Methergine on September 11, 2016, at 9:50 p.m.

26. September 11, 2016, labor and delivery summaries documented the birth of each twin, one at 10:16 p.m., the other 10:17 p.m. No issues regarding delivery were noted, and both infants had good Apgar scores.

27. A six page typed "Surgery" form detailed the patient's preoperative, intraoperative, and postoperative condition, as well as the surgery performed and the twins' conditions.

28. A September 11, 2016, Surgical Pathology and Cytology Requisition form documented the submission of the two placentas for examination. The clinical history and diagnosis stated: "34 week [intrauterine pregnancy] in labor, twin pregnancy." The procedure performed was a primary C-section to deliver twin babies. A September 12, 2016, Surgery Pathology Report documented the results of the examination of those two placenta as being "unremarkable."

29. The records contained numerous documents including a 35-page Post Procedure Assessment Report reflecting the patient's post-C-section condition, an 8-page Vital Sign Report with vital signs taken at 5 to 15 minute intervals, Nursing Notes, Rapid Response Team reports, Code Blue reports, and other examinations performed or test results. The findings documented in the records contained the times the events allegedly occurred, although the entries were made several minutes and sometimes

several hours later. The patient's condition will be chronologically listed below, even though her condition was not entered in the chart at those times.

Entries in the Records Regarding Condition in PACU

30. On September 11, 2016, at 11:00 p.m. the patient arrived at the Post Acute Care Unit (PACU). She was drowsy and cooperative. She had no cardiovascular or respiratory signs or symptoms, but was given oxygen to maintain her oxygen saturation rate of 90 percent. Her incision dressing was clean, dry, and intact with no drainage. Her abdomen was soft and round with no signs/symptoms. She had scant, small vaginal bleeding. The patient's fundus was firm, its location was one finger width above the umbilicus, and her genitourinary (pelvic) signs and symptoms were normal. The patient had no pain.

31. At 11:00 p.m. the patient's blood pressure and pulse were normal.

32. At 11:05 p.m. the patient's blood pressure and pulse were normal.

33. At 11:10 p.m. the patient's blood pressure and pulse were normal.

34. At 11:15 p.m. the patient had no cardiovascular, respiratory, or gastrointestinal signs or symptoms. She was drowsy and cooperative. Her incision dressing was clean, dry, and intact with no drainage. Her abdomen was soft and round. Her genitourinary exam was normal. There was scant, small vaginal bleeding. Her fundus was firm and one finger width above umbilicus. No pain was observed or stated.

35. At 11:15 p.m. the patient's blood pressure and pulse were normal.

36. At 11:30 p.m. the patient was reassessed by the PACU nurse. She was easily aroused, drowsy, and cooperative. She had no cardiovascular or respiratory signs or symptoms. Her incision dressing was clean, dry, and intact with no drainage. Her abdomen was soft and round with no signs or symptoms. She had scant, small vaginal bleeding. Her fundus was firm, its location was one finger width above umbilicus, and her genitourinary examination was normal. There was no pain observed or stated.

37. At 11:30 p.m. the patient's blood pressure and pulse were normal.

38. The records contained two separate entries for assessments at 11:45 p.m. One assessment was entered in the chart on September 12, 2016, at 12:06 a.m. The other assessment was entered in the chart on September 12, 2016, at 1:35 a.m. No explanation for this was offered at hearing.

39. The first assessment at 11:45 p.m. noted the patient to be easily aroused, drowsy, and cooperative. Her cardiovascular and respiratory examinations showed no signs or symptoms. Her incision dressing was clean, dry, and intact with no drainage. Her abdomen was soft and round. She had hypoactive bowel sounds (reduced bowel sounds that can occur following abdominal surgery), complained of nausea, and was given medication. She had small, scant vaginal bleeding. Her fundus was firm, its location was at umbilicus, and her genitourinary examination was normal. The patient complained of suprapubic pain at a 5/10 level that had just begun.

40. The second entry for the assessment at 11:45 p.m. indicated the patient was easily aroused, drowsy, and cooperative. Her cardiovascular and respiratory examinations showed no signs or symptoms. Her incision dressing was clean, dry, and intact with no drainage. Her abdomen was soft and round with hypoactive sounds. She complained of nausea for which medication was given. She had scant, small vaginal

bleeding. Her fundus was firm, located at one finger width above umbilicus, and her genitourinary examination was normal. No pain was observed or stated.

41. At 11:45 p.m. the patient's blood pressure was low at 84/56 and her pulse was normal.

42. At 11:55 p.m. pain medication and antiemetic medication (medication to prevent vomiting) were given to the patient.

September 12, 2016, Treatment

43. At 12:00 a.m. the patient's blood pressure was normal at 124/56 and her pulse was normal.

44. On September 12, 2016, at 12:01 a.m. the patient was reassessed by the PACU nurse. She was easily aroused, drowsy, and cooperative. Her cardiovascular and respiratory examinations were normal. Her incision dressing was clean, dry, and intact with no drainage. Her abdomen was soft and round with hypoactive sounds. She complained of nausea and the intervention was "medication given." She had small, scant vaginal bleeding. Her fundus was firm, was one finger width above umbilicus, and her genitourinary examination was normal. No pain was observed or stated.

45. The patient was reassessed by the PACU nurse at 12:15 a.m. She was easily aroused, drowsy, and cooperative. Her cardiovascular and respiratory examinations had no signs or symptoms. Her incision dressing was clean, dry and intact with no drainage. Her abdomen was soft and round. She had hypoactive bowel sounds and nausea for which medication was given. There was a small vaginal bleeding. Her fundus was firm and its location was at umbilicus. The genitourinary examination was normal. Peri Care was performed and the patient's Peripad was

changed. (Peri care, also known as perineal care, involves cleaning the private areas of patients; a Peripad is a pad covering the perineum used to cover a wound or to absorb the menstrual flow.) No pain was stated or observed. Pain and antiemetic medications were given. (It appears the administration of pain medication was part of the previous order for the prior pain complaints.)

46. At 12:15 a.m. the patient's blood pressure and pulse were normal.

47. At 12:30 a.m. the patient was reassessed. She was awake, restless, and cooperative. Her cardiovascular and respiratory examinations were normal, but the neurological exam indicated the action/intervention taken was "oxygen applied" at room air, but this was not explained at hearing. Her incision dressing was clean, dry and intact, with no drainage. Her abdomen was soft and round with hypoactive sounds. She complained of nausea and was given medication. There was small vaginal bleeding. Her fundus was firm, at umbilicus, and her genitourinary examination was normal. Peri Care was performed and her Peripad was changed. The patient complained of suprapubic pain that was at a 6/10 level which had begun at 11:45 p.m.

48. At 12:30 a.m. the patient's blood pressure and pulse were normal.

49. At 12:40 p.m. the patient's blood pressure was low at 51/40 and her pulse was high at 114.

50. At 12:42 a.m. the Rapid Response Team was called because the patient was extremely restless, agitated, and hypotensive. "Dr. King already spoken to 2 units [packed red blood cells] ordered stat." The emergency room staff was present. The emergency room physician was present. A second line was started by the emergency room nurse. The house supervisor recorded. Abdominal distention was noted. This note was not entered in the nursing chart until 2:40 a.m.

51. The "Rapid Response Team (RRT) Flow Sheet" documented that the team was called at 12:42 a.m., and the initial responder arrival time was 12:43 a.m. The sheet identified the respiratory care practitioner and house supervisor/unit director/charge nurse as the team members present. The sheet also identified that at 12:45 a.m. the physician responded. Pursuant to the uncontradicted testimony offered at hearing, the physician member of the Rapid Response Team is the emergency room physician. The sheet contained a section titled "What Prompted The Nurse To Call The Rapid Response Team? (Check All That Apply)" and then contained several columns and boxes identifying reasons in each column for why the team was called. In the column marked "Staff Concern" the box checked was "Not looking right (gut feeling)." The "Respiratory Status" and "Cardiac Status" columns did not have any boxes checked. The "Change in Blood Pressure" column had the boxes "SBP" and "DBP" checked, presumably meaning systolic blood pressure and diastolic blood pressure. The "Change In Neuro Status" column had the box marked "Lethargic" checked. The "Chest Pain" column had no boxes checked. The "Fluid Status" column had the box marked "1>0" checked. The "Other (Specify)" column had no entries. The "Background" section of the sheet indicated that the patient was "postop C-section, 40 [years] female, patient of Dr. King." Her recent invasive procedure was "epidural - morphine." The "Assessment" section documented that her blood pressure was 51/42, her pulse was 98, her respiratory rate was 21, her temperature was 98.2, her breath sounds were clear, her cardiac rhythm was regular, her neuro assessment was lethargic, she was on oxygen at 10 liters per minute with a simple mask. The section marked "Recommendation (state what the RR team thinks should be done):" contained five options for the team to check. Those options were: "Initiate Code Blue/White; Transfer patient ICU; Physician to come and see patient; Physician to discuss status with patient and family; and Continue monitoring on current unit." The team checked the box

marked "Continue monitoring on current unit." In the "Patient Outcome:" section the box marked "Stayed on same unit" was checked. The Rapid Response Team end time was 12:50 a.m., eight minutes after being called.

52. A document titled "Rapid Response Team Protocols" identified the orders given by the emergency room physician and he signed the document.

53. The patient was reassessed by the PACU nurse at 12:45 a.m. She was awake and restless. Her cardiovascular examination noted hypotension. Her respiratory examination was normal. Her incision dressing was clean, dry, and intact with no drainage. Her abdomen was soft, round and distended with hypoactive sounds. The PACU nurse documented: "Dr. King notified of [abdominal] distention and hypotension, 2 units of [packed red blood cells] ordered stat. Also Rapid Response called when [blood pressure] dropped to 51/42. Responded to fluids. Up to 90/49." A second line was started by the Rapid Response team. The patient had small vaginal bleeding. Her fundus was firm, its location was at umbilicus, and her genitourinary exam was normal. Peri Care was performed and her Peripad was changed. The patient complained of suprapubic pain at a 6/10 level.

54. Dr. King's untimed telephone order to administer two units of packed red blood cells to the patient was in the physician orders section of the records.

55. At 12:45 a.m. the patient's blood pressure and pulse were normal.

56. The patient was reassessed at 1:00 a.m. by the PACU nurse. She was awake, restless, and apprehensive. The cardiovascular examination noted hypotension. Her respiratory evaluation was normal. Her incision dressing was clean, dry, and intact with no drainage. Her abdomen was soft, round, and distended, with hypoactive bowel sounds. She complained of nausea and was given medication. She had small vaginal

bleeding. Her fundus was firm, at umbilicus, and her genitourinary examination was normal. Peri Care was performed and her Peripad was changed. Her suprapubic pain remained at a 6/10.

57. At 1:00 a.m. the patient's blood pressure and pulse were normal.

58. At 1:15 a.m. the PACU nurse verified the checklist for transfusion.

59. At 1:15 a.m. the first unit of blood was started. The patient was on oxygen with a mask and her vital signs were improving. The PACU nurse entered this note in the records at 2:40 a.m.

60. At 1:15 a.m. the patient's blood pressure and pulse were normal.

61. At 1:20 a.m. the patient's hemoglobin was 6.4 (reference range 12.0-16.0) and her hematocrit was 20.4 (reference range 37.0-47.0). Both levels were in the very low ranges.

62. At 1:30 a.m. the patient's blood pressure and pulse were normal.

63. At 1:45 a.m. the patient's blood pressure and pulse were normal.

64. At 1:50 a.m. the patient received a transfusion of packed red blood cells.

65. At 1:50 a.m. the "1st unit of blood completed." The PACU nurse entered this in the nursing notes at 2:40 a.m.

66. The patient was reassessed by the PACU nurse at 2:00 a.m. She was awake, cooperative, and apprehensive. Her cardiovascular exam showed hypotension. Her respiratory exam was normal. Her incision dressing was clean, dry, and intact with no drainage. The patient's abdomen was soft, round and distended with hypoactive

sounds. She was given medication for nausea. She had small vaginal bleeding, her fundus was firm, at umbilicus, and her genitourinary examination was normal. Peri Care was performed and her Peripad was changed. The patient's suprapubic pain was a 10/10. Dr. King was notified of the patient's "severe pain and hypotension again."

67. An entry in the nursing records documented that at 2:00 a.m. "sudden onset of severe pain, [abdomen] distended, tympanic, Dr. King called again, 2 units of blood up." The PACU nurse made this entry in the chart at 2:40 a.m.

68. At 2:00 a.m. Dr. King's telephone order was to give an additional dose of Toradol 30 mg to the patient.

69. At 2:00 a.m. the patient's blood pressure and pulse were normal.

70. At 2:05 a.m. the PACU nurse performed the checklist for transfusion.

71. At 2:15 a.m. the patient's blood pressure and pulse as normal.

72. At 2:25 a.m. a transfusion of packed red blood cells was administered.

73. At 2:30 a.m. "[Name] RN from [labor and delivery] came over to help asses[s] [patient] [Name] OB [technician] as well. Stat ultrasound per Dr. King." The nurse made this entry in the chart at 2:40 a.m.

74. At 2:30 a.m. the patient's blood pressure and pulse were normal.

75. At 2:45 a.m. the patient was medicated for severe pain. Her vital signs were better, her nausea was improving, and the ultrasound was being done. "Stat read to be done by online." The PACU nurse made this entry in the records at 2:40 a.m.

76. At 2:45 a.m. the patient's blood pressure and pulse were normal.

77. At 3:00 a.m. the patient's blood pressure and pulse were normal.

78. At 3:10 a.m. the PACU nurse documented that Dr. King was "notified of preliminary ultrasound results, [vital signs] stable also notified of original [hemoglobin and hematocrit] results prior to blood transfusions. Ok[ay] to continue to monitor [patient] then may transfer to floor after 1 hour of monitoring if stable."

79. At 3:15 a.m. the patient's blood pressure and pulse were normal.

80. On September 12, 2016, at 3:18 a.m. the limited abdominal ultrasound that Dr. King had ordered at 2:30 was performed. Of note, it was not explained how the PACU nurse could inform Dr. King at 3:10 a.m. about the results of an ultrasound that was not performed until 3:18 a.m. offering further proof that the times in the chart may not be accurate. In any event, at some time after the ultrasound was performed, Dr. King was verbally advised of its results.

81. An untimed Miscellaneous Ultrasound Worksheet contained handwritten entries noting that the history was that the patient was status post C-section five hours ago and now had a distended abdomen with pain. The area of interest was "pelvis/abd[omen] for bleeding." In the Comments section the following was handwritten: "Small amount of fluid seen in left lower quadrant/adnexa; no fluid seen in right lower quadrant/write adnexa area; suboptimal view of upper abdominal quadrants - right upper quadrant and left upper quadrant filled with gas - no masses or fluid could be seen in these areas."

82. The Final Ultrasound Report, was written by the radiologist and entered in the chart at 5:56 a.m. It was countersigned by a second physician who agreed with the findings at 8:22 a.m. The procedure was "[Ultrasound] pelvis limited" and the reason for it was to rule out bleeding post C-section. A limited abdominal ultrasound

was performed. The patient's history was bilateral status post C-section, distended abdomen and pain, evaluate for bleeding. The Findings were: "Small amount of fluid is seen in the left lower quadrant/left adnexa. There is no free fluid seen in the right lower quadrant/write adnexa. Suboptimal views of the upper abdomen due to overlying bowel gas without definite mass or fluid identified." The Impression was: "There is a small amount of fluid in the left lower quadrant/adnexa."

83. At 3:30 a.m. the patient's blood pressure and pulse were normal.

84. At 3:40 a.m. pain medications were given.

85. At 3:45 a.m. the patient's blood pressure and pulse were normal.

86. At 4:00 a.m. the patient's blood pressure and pulse were normal.

87. At 4:15 a.m. the patient's blood pressure and pulse were normal.

Entries in the Records when the Patient was on the Floor

88. On September 12, 2016, at 4:30 a.m. the patient was transferred to the floor. The last entry from the PACU nurse documented that the patient was admitted to Room 120-A, her vital signs were stable, her vaginal bleeding was small with no clots, her pain was much better, her nausea was gone, and her general condition was stable. The report was given to the floor nurse.

89. At 4:40 a.m. the Labor and Delivery nurse (floor nurse) documented she assumed care from the PACU nurse, received the report on the patient's current status, and assessed the patient. The patient's general appearance was clean, mild distress, and sleepy. She was alert and well hydrated. Her cardiovascular and respiratory assessments were normal. Her abdomen had hypoactive bowel sounds, and was

"distended, firm, large girth." The genitourinary examination had no reported problems, no evidence of trauma, a normal perineal exam and vaginal bleeding. The patient's dressing from the C-section was clean, dry and intact. There was no drainage from the incision. The patient's fundus was firm, three fingerbreadths above the umbilicus, and its position was right side. The patient had cramps and pain. Peri Care was performed and her Peripad was changed.

90. Although the patient's fundus was now three fingerbreadths above the umbilicus, after having been at umbilicus for several hours (since 12:15 a.m.), the floor nurse did not think there was anything significant about that new finding. The floor nurse thought it was due to the patient having delivered twins and she did not report this new finding to anyone or notify Dr. King.

91. At 4:48 a.m. the patient's blood pressure was low at 61/52, and her pulse was high at 123.

92. At 4:49 a.m. the patient's blood pressure was low at 73/54, and her pulse was high at 127.

93. At 4:54 a.m. the patient's blood pressure was low at 74/58, and her pulse was high at 122.

94. At 4:56 a.m. the patient's blood pressure was low at 81/62, and her pulse was high at 108.

95. At 4:58 a.m. the patient's blood pressure was low at 97/71, and her pulse was high at 110.

96. At 5:04 a.m. the patient's blood pressure was low at 75/58, and her pulse was high at 113.

97. At 5:08 a.m. the patient's blood pressure was low at 98/72, and her pulse was high at 104.

98. At 5:33 a.m. the patient's blood pressure was normal and her pulse was high at 120.

99. At 5:38 a.m. the patient's blood pressure was normal and her pulse was normal.

100. On September 12, 2016, at 5:45 a.m. the patient's hemoglobin was 6.9 (reference range 12.0-16.0) and her hematocrit was 21.2 (reference range 37.0-47.0). Both levels were in the low ranges and both results had been verified by repeat analysis.

101. The floor nurse never notified Dr. King or any other person about these changes in the patient's blood pressure or her lab results recorded between 4:48 a.m. and 6:00 a.m.

102. On September 12, 2016, at 6:00 a.m. an anesthesiologist documented in a Doctor's Progress Note that the patient's blood pressure was 99/76.

103. On September 12, 2016, at 6:30 a.m. the anesthesiologist wrote: "notified Dr. King patient needs to be transferred to ICU & consult [cardiologist]. Awaiting [hemoglobin and hematocrit]." This was Dr. King's first notification of a change in the patient's condition after she was transferred from the PACU to the floor.

104. On September 12, 2016, at 6:40 a.m. the anesthesiologist's telephone order was to consult with the cardiologist and transfer the patient to telemetry.

105. Dr. King's telephone order at 6:40 a.m. was to transfuse two units of packed red blood cells.

106. Dr. King's telephone order at 7:30 a.m. was to transfer the patient to the ICU for observation.

107. Dr. King gave a STAT order to transfuse blood at 7:35 a.m. Several Transfusion Records documented the blood transfusions given to the patient as ordered by the treating physicians.

108. The floor nurse reassessed the patient at 7:45 a.m. She was in no acute distress, alert and clean. Her cardiovascular, neurological and respiratory evaluations were normal. Her abdomen was distended, firm, had a large girth, and hypoactive bowel sounds. Her genitourinary exam had no reported problems, a normal perineal exam, and vaginal bleeding. Peri care was performed. Her fundus was firm, its height was 3 fingerbreadths above the umbilicus, and on the right side. No pain was observed or stated. Her incision dressing was clean, dry and intact with no drainage.

109. At 7:50 a.m. the patient's blood pressure was normal and her pulse was high at 115.

110. At 7:50 a.m. a different nurse made the following entry: "Spoke with [the cardiologist]. Info given re: [patient] current condition and labs. Informed him that we are transferring [patient] to ICU. No new orders given at this time."

111. At 8:15 a.m. that same nurse made the following entry: "Transferred [patient] to ICU at 08:10 with assistance from [a third nurse]. [A fourth nurse] assumed care of [patient]. She received report earlier from [floor nurse].

112. A September 12, 2016, nursing entry documented that the patient had been received from the floor at 8:30 a.m. She arrived on the unit and was tachypneic (fast breathing), tachycardic (fast heartbeat), and hypotensive. She was receiving Pitocin, had received two units of packed red blood cells, and was to receive two more units. While waiting for the blood to arrive to the floor, the patient was becoming increasingly anxious, and the Rapid Response team was called to bedside. A non-breather mask was placed while waiting for the team. The patient became unresponsive and was frothing at the mouth. Code blue was initiated. The ER physician came to the bedside with the ER nurses. ROSC was obtained (this acronym was not explained at hearing). The nurse called Dr. King to notify him that his patient had coded. Orders were given to give the two remaining units of blood and to call the cardiologist. The nurse wrote "I told him that the patient's hemoglobin had only come up from 6.4 to 6.9 from 2 units" of packed red blood cells. "Expressed concerns that the patient may still be bleeding. Also notified him that the patient had stated that she was having excruciating back pain just prior to becoming unresponsive." (It is unclear from the nursing notes if the nurse meant that she had this discussion with Dr. King or with the cardiologist.) "10 minutes later, Dr. King called back and stated that the patient is to be brought back down to the O.R. Patient was brought to the O.R. and remained stable throughout the duration of transport to the O.R. Upon returning to the unit I heard a code blue called in the O.R. Immediately I rushed back down to the O.R." the nurse wrote further:

> We coded that patient for over 2.5 hours. Once we achieved ROSC [acronym not explained], patient was transported back up to the ICU. We continued transfusing [packed red blood cells], FFP [acronym not explained], and platelets. [Resuscitation medications given] at maximum rate.

> Obtained orders for [additional medications]. Patient coded again and the ER [doctor] who had coded her from the previous 4 times came to the bedside. We were unable to revive the patient. Patient had began [*sic*] to bleed from every orifice at this point as well. [The remainder of the note documents the family, chaplain, and social worker notifications.]

113. A 9:20 a.m. entry from the respiratory care therapist documented the Code Blue treatment being rendered, that CPR was started on arrival to the ICU, that the patient had been intubated, and that the patient was transported to the operating room after intubation.

114. A September 12, 2016, Code Blue Sheet documented the treatment administered by the team between 9:19 a.m. and 9:51 a.m. The entry at 9:23 a.m. indicated Dr. King was notified. The narrative section stated the patient was 34 weeks postpartum, had hemoglobin of 6.4 to 6.9, a distended abdomen, complained of pain, and was anxious. As documented, the team consisted of several members including the emergency department physician.

115. A document titled "Evaluation of Code Blue" signed at 9:50 a.m. noted that the patient was in full code, had been intubated, had a line established, and recorded the efforts performed during the code. Telemetry printouts documented the patient's status over time.

116. The cardiologist's telephone order at 10:00 a.m. was to transfuse three additional units of packed red blood cells for a total of five, to administer levophed, to

consult with two other physicians, get a CBC after the three units of packed red blood cells were given, and ABG now.

117. The anesthesiologist's progress note stated the patient was brought to the OR at 10:30 a.m. and was on continuous ventilation.

118. The September 12, 2016, Operative Report from the vascular surgeon contained the following "Brief History:"

> The patient apparently underwent a cesarean section for delivery of twins earlier in the day and following this continued to have bleeding.[1] Her surgeon, Dr. King, was treating her at that time and already had performed supracervical hysterectomy, which was then complicated by incessant and uncontrollable bleeding. Due to the difficulty controlling the bleeding, Dr. King requested that I be called emergently.

In the "Procedure in Detail" section the vascular surgeon wrote:

> I presented to the operating room where the patient was being managed by Dr. King, [a general surgeon], and [an anesthesiologist] for anesthesia. The patient had a low abdominal incision, through which I visualized a large

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[1] It was not explained at hearing where the vascular surgeon got this information, and as found herein, the evidence did not support his assumption that the patient had continued bleeding after her C-section.

> retroperitoneal hematoma. There was persistent bleeding from the superior left upper edge of the hematoma and following control of the losing from the hematoma, the hematoma was digitally dissected and I found an uncontrolled left ovarian vein, which was continually bleeding. This was controlled by application of hemoclip as well as application of a ligature around a right-angled clamp placed onto the ovarian vein. The bleeding stopped immediately.
>
> Following cessation of bleeding, the patient's procedure was then continued by Dr. King after I left the operating room. Dr. King will dictate the remainder of the procedure prior and after my departure.

119. A handwritten "Doctor's Operative Report," written by Dr. King on September 12, 2016, noted the preoperative diagnosis was "postpartum hemorrhage [illegible] atony." The postoperative diagnosis was "[illegible] uterus atony; DIC. The indication for the procedure was [illegible.] Dr. King identified the anesthesia type, anesthesiologist and assisting surgeon. His operative findings were "uterus atony, retroperitoneal hematoma (1500 cc)." The procedure was subtotal hysterectomy, left SLO, abdominal packing." There were no complications and the estimated blood loss was [illegible, illegible] the patient's condition on transfer to the PACU was [illegible].

120. A seven page typed "Surgery" form detailed the surgery performed on September 12, 2016, and the patient's condition.

121. On September 13, 2016, at 12:07 a.m.[2], Dr. King dictated his "Operative Report" documenting the September 12, 2016, exploratory laparotomy, subtotal abdominal hysterectomy performed due to uterus atony, and the vaginal packing performed to stop the tissue oozing from the pelvic cavity after the hysterectomy, that he performed. His report identified the assisting surgeon and anesthesiologist who used general anesthesia. Dr. King's preoperative diagnoses were (1) postpartum hemorrhage, rule out uterus atony and (2) rule out disseminated intravascular coagulopathy (DIC). His postoperative diagnoses were (1) postpartum hemorrhage, (2) uterus atony, (3) retroperitoneal hematoma, and (4) DIC. The patient's estimated blood loss was "about 2000 mL." Dr. King documented the surgery he performed in the "Procedure in Detail" section, noting that the patient was sent to the operating room from ICU because of postpartum hemorrhage. Dr. King entered the peritoneal cavity, there was not much blood inside the pelvic abdominal cavity but the uterus was severely enlarged due to uterus atony. He noted that after opening the incision of the uterus, "there was a large amount of un-coagulated blood with some blood clot inside the uterus which was evacuated" and then Dr. King clamped and ligated various ligaments "all the way down to the" left and right uterine artery pedicles. His report described the packing and closing he performed, including how closing was performed "while the CPR team was performing chest compressions as well as maintain the heart beat and blood pressure by the ICU team as well as Fast Response Team." The patient was sent to ICU given her critical condition. Dr. King's "Plan" was: "There were some multiple units of packed RBCs as well as platelets and fresh frozen

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[2] Although there was argument made that Dr. King wrote this report the next day, which is technically correct, it was created just a few minutes after midnight on the day he performed the surgery.

plasma. Please refer to the anesthesiology as well as the Fast Response Team records." Dr. King electronically authenticated this report on October 6, 2016, at 6:03 p.m., the same date and time that he electronically authenticated his C-section operative report.

122. The anesthesiologist documented what occurred during the procedure, including the fact that 14 units of packed red blood cells were given and code blues with chest compressions occurred during surgery.

123. The patient was transferred to the ICU following surgery where she was monitored, provided care, and expired at 4:50 p.m. on September 12, 2016.

124. Code Blue Sheets documented the treatment administered by the team between 12:00 p.m. and 12:24 p.m., between 12:27 p.m. and 12:46 p.m., between 12:59 p.m. and 1:16 p.m., and between 4:45 p.m. and 4:50 p.m. when the patient was pronounced deceased. The team consisted of several members including the emergency department physician.

125. On September 13, 2016, at 7:43 p.m., Dr. King dictated a "Death Summary" that he electronically authenticated on October 6, 2016. He noted the patient's admitting diagnosis was "Twin pregnancy at 32 weeks in active labor." In the "Hospital Course" section he wrote:

> This was a 40-year-old female patient who was admitted on September 11, 2016, at around 11 o'clock due to a 32-week twin pregnancy in active labor, dilated to 6 cm. So, a primary cesarean section was attempted to deliver two baby boys. Postoperatively, her condition was involved with an unstable blood pressure and 4 units of blood transfusion were given. The patient eventually developed amniotic fluid

> embolism and a sub total abdominal hysterectomy was done as well as abdominal packing.
>
> CPR was attempted because of cardiopulmonary arrest. The patient expired at 1650 hours due most likely to amniotic fluid embolism.

Dr. King wrote that the patient's "Final Diagnoses" were (1) [t]he patient expired, most likely due to an amniotic fluid embolism; (2) Uterine atony; and (3) Disseminated intravascular coagulopathy.

126. The Surgical Pathology and Cytology Requisition form documented that on September 12, 2016, the specimens submitted were uterus and blood clots. The preoperative diagnosis was abdominal bleeding, and an abdominal hysterectomy had been performed. A Surgical Pathology Report documented the findings of those specimens. The cervix had mild chronic cervicitis; the endometrium had hemorrhagic necrotic decidua, the myometrium and the serosa for each were unremarkable.

127. On September 12, 2016, at 6:59 p.m., the Emergency Department physician, electronically signed a 13-page Emergency Department Record, which summarized the patient's care and clinical findings. This emergency department physician's first contact with the patient occurred on September 12, 2016, at 6:50 p.m., and the chief complaint was Code Blue. The narrative section stated: "There were 5 code blues on this patient one in the ICU and then 3 in the OR and then 1 more in the ICU. Patient is a 40-year-old female who delivered twins by C-section this morning and had a low hemoglobin of only six she was given two units of packed red blood cells are [*sic*] increased to 6.9 and she was put in ICU."

The "Vital Signs" section noted the last set of vital signs taken at 7:50 a.m. showed a blood pressure of 93/78, a pulse of 115, and oxygen saturation of 100 percent on 2 liter of nasal cannula. The emergency department records also contained various lab results including:

- hemoglobin of 9.1 (normal range 12.0-16.0) and hematocrit of 28.9 (normal range 37.0-47.0) on September 11, 2016, at 9:40 p.m.;
- hemoglobin of 6.4 (normal range 12.0-16.0) and hematocrit of 20.4 (normal range 37.0 - 47.0) on September 12, 2016, at 1:20 p.m. when the patient was "in recovery room"; and
- hemoglobin of 5.5 (normal range 12.0-16.0) and hematocrit of 17.9 (normal range 37.0 - 47.0) on September 12, 2016, at 3:05 p.m.

The emergency department record documented the orders given by the various treaters and the section titled "ED Course/Medical Decision Making" stated (errors in original):

> ED course patient was never in the emergency department she was in the ICU ran a code up there for 40 or 50 minutes and during the course of the code we were able to get her heart started we gave her fluids gave her many rounds of epinephrine and we gave her a central line and intubated her. She developed a blood pressure which for a while appeared to be good but we felt that she was bleeding internally and we called [the cardiologist] and Dr. King Dr. King came in and took her to the OR.

In OR he took out the uterus stop most of the bleeding and sutured her up in the process of closing code was called and we ran another 50 minute or 50 minutes code we gave her epinephrine several many times and bicarb x2 and atropine and after 50 minutes and got her heart running with a fairly decent blood pressure.

2 more codes of the OR there were shorter than the first 1 and resulted in blood pressure following patient has another set central line put in the right groin had good ABGs to go off of an patient developed a good blood pressure after each of the next 2 codes.

After 4 5 hours we had another code in the ICU and this time it was obvious that the patient was developing DIC [disseminated intravascular coagulation] ran the code for 10 minutes or so and at this point we decided to call it she did not have any reasonable rhythm and they had given 16 units of blood over 8 hours that we were running codes.

The "Disposition" at 6:55 p.m., was a diagnosis of "CODE BLUE x5 with the fifth one resulting in demise." The condition was "expired" and the critical care time was listed as two hours.

128. The anesthesiologist's entry in the progress notes on September 18, 2016, titled "[illegible] Anesthesia" documented that Dr. King performed a total abdominal hysterectomy with massive blood in the abdomen; continued to give fluids, called code blue during the procedure; team have all the notes; at 1:20 p.m. Dr. King

re-opened to pack the belly. The belly was full of blood and packed. Blood was oozing out from the NG tube. The patient was brought to the ICU in [illegible] condition to be [illegible] by fresh frozen plasma and platelets as soon as possible. Of note, no explanation was offered as to why the anesthesiologist entered this note six days after the patient expired.

129. The Death Certificate "signed" by Dr. King on September 27, 2016, listed the patient's immediate cause of death as cardiopulmonary arrest, and her underlying causes of death as uterine atony, disseminated intravascular coagulation (DIC), and amniotic fluid embolism. Complainant's expert's opinion that the death certificate was inaccurate because it did not identify "internal bleeding" as a cause of death was unpersuasive. A fair reading of the death certificate shows that it documents that the patient bled to death because of uterine atony, which means the uterus does not clamp down and continues to bleed postpartum.

Dr. King's Summary of Care

130. On June 24, 2019, the attorney who represented Dr. King in the civil litigation authored a letter to the board's investigator on Dr. King's behalf summarizing Dr. King's care and treatment of the patient. Although complainant questioned the fact that the letter had been authored by the attorney and not Dr. King, there was nothing untoward or unusual about a physician's attorney preparing such a letter on his behalf and this practice is not uncommon.

Of note, the copy of this letter offered by complainant redacted the entire portion of the letter containing the expert opinions of two physicians who supported Dr. King. One expert was a "board certified Perinatalologist specializing in Maternal-Fetal Medicine," who is a consultant for the Minnesota Board of Medical Practice and a

practicing physician in both Minnesota and Michigan. That expert supported the care and treatment rendered by Dr. King. The other expert was a "[board] certified internal medicine and emergency care physician with a sub-specialization in critical care medicine" who is a Chief Medical Officer at Memorial Healthcare System and an attending physician at Long Beach Memorial Medical Center in California. That physician supported Dr. King's diagnosis of amniotic fluid embolism. A complete copy without the redactions was offered by Dr. King and received in evidence. Complainant's expert could not answer whether he had reviewed an unredacted copy of the letter, but he made no comment in either his report or his testimony regarding these favorable opinions, although he would assume that because there was civil litigation, there were experts supportive of Dr. King's care of the patient.[3]

131. The rest of the letter summarized the patient's admission and delivery and noted that a "transient hypotensive episode was cyanosis was observed around [10:50 p.m.], while the patient was still in the operating room. The significance of this observation was not apparent at that time. In retrospect, Dr. King believes this episode may have been initial sign of [amniotic fluid embolism]." The letter stated the patient was transferred to the recovery room at approximately 11:10 p.m. in stable condition. The letter states further:

> Shortly after the conclusion of the cesarean section, Dr. King was contacted by another hospital to perform a cesarean section. After confirming that [the patient] was in

[3] While those opinions were not relied upon in reaching any conclusions in this decision, the redaction was concerning.

stable condition in the recover[y] room, he traveled to the other facility.

Just before Dr. King began a cesarean procedure on another patient, he was contacted for the first time by [the PACU nurse], who updated him on [the patient's] condition.

(ii) September 12, 2016

At approximately [12:40 a.m.] the patient's vitals indicated that her blood pressure was low. Further, the medical charts show that the patient complained about pain and hypotension and abdominal distention. At this time, Dr. King was called and notified of the patient's condition. After receiving the call from [the PACU nurse] at the hospital, Dr. King's [*sic*] ordered 2 two units of [packed red blood cells].

In addition to the call to Dr. King, the Rapid Response Team was also called to assess the patient, per hospital protocol, due to the drop in her blood pressure to 51/42.

Dr. King indicated that it is common for patients to have low blood pressure following surgery, due to the occurrence of regular blood loss during procedures. He explained that the patient's blood pressure was indicative of an average loss of blood for the surgery performed, about 500 cc. Although Dr. King noted that the blood pressure was low, is a common side effect of fluid loss following a cesarean section.

At [12:42 a.m.], patient became "extremely distressed, agitated, [and] hypotensive and started frothing at the mouth." At this time, the emergency room physician started a second line for her. After assessment, the Rapid Response Team recommended monitoring and the continuation of the patient on the "current unit," the recovery room. There were no ICU beds available for the patient at that time.

At [12:45 a.m.], the medical records indicate that the patient had responded positively to the administered fluids. At this time, her blood pressure had increased to 90/46 with a heart rate of 101.

At 1:15 [a.m.], the patient was started on her first unit of [packed red blood cells]. She responded well to the unit of blood and her vital signs improved. Transfusion was completed around 1:50 p.m., at which time she was in stable condition with no signs of distress.

At 1:20 [a.m.] and 1:45 [a.m.], the patient's [hemoglobin] was 6.4 with a [hematocrit] of 20.4. Further, her "transfusion record vitals" recorded at a heart rate of 99, with a blood pressure of 90/49.

Between 1:30 [a.m.] and 2:00 [a.m.], the patient began complaining of a sudden onset of pain and distended abdomen. [The PACU nurse] called Dr. King to notify him of this change in the patient's condition. At approximately 1:30

[a.m.], Dr. King ordered a sonogram to assess the patient's abdominal distention. The hospital does not have an in-house tech during the night shift, so an offsite technician was contacted. Dr. King explained that during his call with [the PACU nurse], he instructed her to wait and monitor the patient's response to a second unit of blood.

At 2:30 [a.m.], [a supervising nurse and an OB tech] arrived to assess the patient for an ultrasound per Dr. King's request.

At 2:45 [a.m.], the patient was medicated for her pain, and her vital signs improved.

At approximately 3:10 [a.m.], Dr. King arrived back to the hospital. He was notified of the patient's preliminary ultrasound results and current vital signs. The ultrasound report did not show any internal bleeding. Additionally, the report showed a small amount of fluid in the lower left quadrant/adnexa, and indicated that distended abdomen was caused by air in the intestine. After reviewing the report, Dr. King recommended that the patient continue to be monitored and could be transferred to the postpartum area after one hour if her vitals remained stable.

The patient was transferred to a post-partum room at 4:30 [a.m.] with stable vitals and minor vaginal bleeding. At the time of her transfer, her vitals recorded with a blood

> pressure 101/74, heart rate of 108, and oxygen saturation of 100. Additionally, the patient reported improved level of pain and no further nausea.
>
> From the hours of 4:30 [a.m.] to 6:30 [a.m.], the patient was continually monitored with frequent vital checks that were noted in her medical record. However, Dr. King was not contacted by anyone at the hospital from 4:30 [a.m.] to 6:30 [a.m.] until [the anesthesiologist] call Dr. King at 6:30 [a.m.].
>
> [The letter documents the patient's vital signs and lab results as noted above in the summary of care.]
>
> At approximately 6:30 [a.m.], [the anesthesiologist] called Dr. King to inform him that the patient's blood pressure was still low and that she wanted to transport her to the ICU for a consult with [the cardiologist]
>
> As of 7:00 [a.m.], and Dr. King arrived at the hospital, the hospital records indicate that there was still no available ICU beds, assistant surgeons, or OR room to assess the patient.

The letter set forth what took place in the ICU, the patient's vital signs, and that "Dr. King contacted '[staff] in the OR' to request that the OR be made available immediately so that the patient can be transferred for emergency surgery." The letter then detailed the surgery and lifesaving measures performed, as well as the patient's condition, noting that "[a]n echocardiogram was performed which supports the diagnosis of [amniotic fluid embolism.]"

The letter also described Victor Valley as "a small community hospital located in Victorville California" with "10 licensed intensive care/coronary care/ICU beds. The letter states:

> In March 2016, a report was prepared for the [California] Office of the Attorney General on the effect on health services in specific communities. The report noted that as of 2014, the emergency department at [Victor Valley] was significantly over-burden, 124% past it desired capacity.
>
> Furthermore, the medical records indicate on September 12, 2016, there was a shortage of ICU beds and attending staff to more closely monitor the patient. The records show, that although [the anesthesiologist] requested that the patient be moved to an ICU bed at approximately 6:30 [a.m.], no beds were available to receive the patient. Under the care of [the anesthesiologist and the cardiologist] during this time, the patient was not moved from postpartum until approximately 8:30 [a.m.].

The letter concluded:

> Dr. King's care this patient complied with the standard of care for obstetricians caring for a patient in the community hospital setting. Unfortunately, [the patient's] pregnancy was complicated with the development of an [amniotic fluid

embolism].[4] Despite the best of care, including interventions by the hospital rapid response team, multiple transfusions of blood, ultrasound, and emergent surgeries, [the patient] did not survive the impact of the [amniotic fluid embolism].

Dr. King's Investigation Interview

132. Dr. King was interviewed by the board's investigator and medical consultant as part of complainant's investigation. Dr. King's attorney, who represented him in the civil litigation, was also present. During the interview Dr. King was asked if this matter had been peer-reviewed by his hospital. He advised that it had been, and his care and treatment of this patient was determined to be within the standard of care and no further actions were taken.

Dr. King described his care and treatment of patient, explaining she was stable when he left Victor Valley at 11:30 p.m. He was at another hospital, approximately one hour away, when he received telephone calls about the patient and issued telephone orders. He was at the other hospital when he ordered the two units of packed red blood cells and when the Rapid Response Team was first called. He later ordered the sonogram via telephone when the patient complained of pain. His review of that sonogram indicated there was no internal bleeding and that the patient was "full of gas - a lot of gas of the intestine." Dr. King was back at Victor Valley at 3:00 a.m. He

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[4] Amniotic fluid embolism is a rare but serious condition that occurs when amniotic fluid or fetal material, such as fetal cells, enters the mother's bloodstream.

agreed that the patient's hemoglobin of 6.4 was pretty low, but he had ordered two units of blood, her blood pressure was stable, and he usually checks hemoglobin levels four hours after transfusion.

Dr. King noted that the patient was transferred to the floor in stable condition but that when her condition became unstable between 4:30 a.m. and 6:30 a.m., he was never notified of those changes until the anesthesiologist called him at 6:30 a.m. He explained that when he was notified, he tried to transfer the patient to the ICU but no beds were available until 8:30 a.m.

Dr. King also contacted the cardiologist to assist with the patient's care, and he was "downstairs in the OR" trying to secure an operating room. He finally secured one and described his findings during the second surgery, and his request that the vascular surgeon assist because of those findings. Dr. King was also being assisted by a general surgeon during the procedure. Dr. King stated he did not make the diagnosis of amniotic fluid embolism until after performing the surgery.

Dr. King was asked whether he made any changes at Victor Valley following this incident. He explained that because of his leadership position he worked with the hospital to have "a 24 hours labor program" installed that he oversees. With this program, Victor Valley now has an obstetrician in-house 24 hours per day and "an ICU stay" available 24 hours.

Dr. King's Testimony at this Hearing

133. Dr. King described his first visit on June 20, 2016, with the patient. He completed the initial physical examination of her which was normal. She was just a little obese and her uterine size was at 22 weeks. She had transferred to his care from another physician a few blocks down the road because that physician discontinued her

care because she was noncompliant. Dr. King's plan was to get all of the patient's former records, including her prenatal labs, and input that information into his records. He explained that because she was pregnant with twins, she was automatically in a high risk category; she was also high risk because she was aged 40, an advanced maternal age. It was difficult to estimate her due date because she was already late in her pregnancy. The sonogram put her gestational age at 20 to 22 weeks, and there is a plus or minus two week margin of error on ultrasounds taken during this stage of the pregnancy. This is why prior sonograms are so valuable.

134. Dr. King explained there are two entries for the June 20 visit because of the EMR issues. The record is only designed for a single pregnancy, not twins. So when the twins are in different positions, as occurred here, a second entry is created when the different twin's position is entered. Since inception, Dr. King has been asking the vendor to correct this issue, but it still has not. The reason there is only one entry for the September visit was because both babies were in the vertex position. Dr. King explained that that entry in the records that the visit was September 7, 2017, is a typo, which anyone would know reading the records, as the previous entries all document 2016 visit. Again no evidence refuted Dr. King's testimony regarding these EMR issues. At the second visit he noted the patient's noncompliance because she had not been seen in or over two months, and he never saw her again until her presentation at the hospital for delivery.

135. Dr. King described the EMR system used in his office since approximately 2013 or 2014 when federal requirements made all physicians who receive federal funding switch from paper records to EMR. There have been many problems with the EMR system which Dr. King has been trying to address since first getting the program. The issue is the program was uniformly created and is not fully compatible with an

OB/GYN practice. One of the issues is that when there are patients with multiple gestations, in order to enter information about each fetus, the system creates separate entries, as occurred here. Additionally, when the document is printed out, sometimes data is missing, sometimes information is not retrieved, or sometimes it is retrieved in an incorrect manner. These problems exist even today. For example, the 2017 date in his records was not inputted by his office and is most likely the last time someone reviewed the record, likely during the civil litigation. Moreover, because he initially entered the patient's age when he saw the patient in 2016, when the record was pulled in 2017, it automatically updated the patient's age, even though she was deceased. Another issue is the small print of the form, making it difficult to read. Dr. King agreed that all of these issues can cause confusion, but that is how this EMR system works. No evidence was offered refuting Dr. King's testimony regarding the EMR system in his office.

136. When he was notified of the patient's presentation at Victor Valley, he ordered medications to stop labor because she was a high risk patient, and Victor Valley does not have the resources to care for neonatal babies so the plan was to transfer her to another facility that does have a Neonatal Intensive Care Unit (NICU). However, she quickly dilated so the only option was to perform a C-section as soon as possible, and Dr. King went to Victor Valley to do so. He met with the patient and obtained her consents.

137. During the C-section, Dr. King performed a low transverse incision, and was nowhere near the left ovarian vein. He delivered two healthy boys who were transferred to another facility for care as Victor Valley does not have a NICU. Thereafter at 11:30 p.m., Dr. King received a telephone call from another hospital that a woman was in labor and needed medical attention. Before he left Victor Valley, he

checked the patient's vital signs, determined she was stable, and went to the other hospital to perform a C-section.

138. While at the other hospital, he received a telephone call from the PACU nurse advising that the patient had become hypotensive and that the Rapid Response Team had evaluated her. Dr. King ordered two units of blood and a STAT ultrasound which is his "routine order for hypotension after regular, uncomplicated C-section." The Rapid Response Team consists of the emergency room physician, a nurse, and the house supervisor. In 2016, Victor Valley did not have an OB/GYN hospitalist and the Rapid Response Team was the only resource Physicians had to treat patients in these circumstances and "they were pretty good at it." The emergency room physician was the only other physician available at that time to evaluate the patient, and Dr. King was also in contact with the PACU nurse. Dr. King explained that he has worked with the PACU nurse "many, many times." He testified, that Victor Valley is "lucky to have an experienced nurse like her and I hope I have the same experienced nurse" for all my cases. As he put it, the PACU nurse "knows her stuff."

139. At approximately 1:30 a.m. Dr. King got another call from the PACU nurse updating him regarding the results of the Rapid Response Team intervention. The patient's condition was normal. The PACU nurse next called Dr. King at approximately 2:00 a.m. to advise him of the patient's incisional pain and abdominal distention. The patient had just finished receiving one unit of blood and the second unit was up. Dr. King was not very concerned about the pain complaints because this is the time when the spinal anesthesia typically wears off and the patient was complaining of incisional pain, which would be a normal complaint. The patient's abdomen was tympanic which means it was full of air, not fluid or blood, but one of the reasons he ordered the ultrasound was to confirm there was no internal bleeding.

The PACU nurse also advised that the ultrasound tech had not yet arrived. Dr. King explained that Victor Valley does not have an in-house person during the evening, they contract out for the service, and must wait for that person to arrive, which occurred here. The PACU nurse also told him about the results of her physical examination, which were normal.

140. Dr. King left the other hospital somewhere between 2:30 a.m. and 3:00 a.m. and returned to Victor Valley in case the patient was still unstable or hypotensive after receiving the two units of blood. At this time he still did not know the results of the ultrasound. At approximately 2:30 a.m. he got a telephone call from the PACU nurse who advised that the ultrasound tech had still not arrived. At this time Dr. King ordered a charge nurse to evaluate the patient as she is another asset he had to manage a patient like this. The charge nurse has 25 years of experience with lots of experience managing postpartum bleeding. The charge nurse called him back immediately advising the patient's fundus was at the umbilical level and firm, there was no bleeding and told him that the ultrasound technician had come and was scanning the patient bedside. The ultrasound technician told the charge nurse who told Dr. King there was no internal bleeding and that the patient was full of air. Given that the patient now had a normal blood pressure and a normal ultrasound, Dr. King did not believe there was internal bleeding, if he had, he would have taken the patient to the OR at this time.

141. Between 2:30 a.m. and 3:45 a.m., the patient's vital signs were normal and she was in stable condition. At 3:10 a.m. Dr. King got another telephone call; he was in the parking lot of the hospital and his plan was to go inside if needed. During the call he was told that the patient was stable, her blood pressure was normal, and she had a normal ultrasound. When he was told that there was no bleeding, he believed she was

normal after receiving two units of blood and the ultrasound confirmed there was no internal bleeding. As he was completely exhausted from working the whole night, he decided to rest and to not check the patient because he wanted to let her rest. He gave an order to continue monitoring the patient for one more hour and if stable to transfer her to the floor. At this point while testifying, Dr. King became quite upset, explaining that his decision to transfer the patient to the floor has been bothering him for the past six years because he truly believes that if the patient had remained with the PACU nurse, she would have recognized the change in the patient's condition and she could have immediately been brought to the operating room.

Dr. King testified that he decided not to check the patient at bedside since she was stable, her vital signs were normal, and she was going to be observed for one more hour before going to the floor. Dr. King then fell asleep in his car as he was "dead tired," and awoke 20 to 30 minutes later and went to the physician's lounge where he could access the patient's records and read the ultrasound report to check that the patient was stable. He was also able to check her vital signs. The actual ultrasound report was not yet available on the system, but he was able to check her vital signs and labs and he could see part of the ultrasound report as those are documented in real time in the records. His review of those documents confirmed that there was no internal bleeding, and he did not think any more information could be gained by physically examining the patient at this time. Thus, he changed his plan as he was convinced she was 100 percent stable and would be continue to be observed for another hour before going to the floor to make sure she was "really, really normal." If not, he was ready to take her to the operating room. Dr. King then went to his on-call apartment two miles away, located by his office, so that he was close to the hospital in case he was needed. As it was now early Monday morning and his Monday

office visits are extremely busy, he wanted to rest as he had to take care of his other patients.

142. At approximately 6:30 or 7:00 a.m. he received a telephone call from the anesthesiologist who advised that she checked the patient before doing her morning rounds and found her to be unstable and hypotensive and she had called for the patient to be transferred to ICU and for the cardiologist to manage her in the ICU. However, ICU had no beds, which was why the anesthesiologist called Dr. King. Prior to the call from the anesthesiologist, Dr. King never received any calls that the patient's condition had deteriorated after she was transferred to the floor. Dr. King immediately went to the operating room and tried to find an opening, but all the rooms were full.

Victor Valley is a very small hospital, and he could not get an operating room at that time for the patient. While he was trying to obtain an operating room, the cardiologist was trying to manage the patient. During this time, Dr. King stayed down in the operating room area because he was doing all he could to "bump another doctor's patient," so he could operate on this patient. He explained how all the other physicians' patients are important to them so he needed to stay down there to plead his case and speak with the operating room manager to get a room opened up. He later learned the patient could be transferred to the ICU at 8:30 a.m., and that she coded at 9:20 a.m., at which point Dr. King could not wait any more, and he had to forcefully bump another physician so he could perform emergency surgery, which resulted in him performing a hysterectomy.

143. During the second surgery, there was oozing at the C-section incision into the peritoneal cavity and retroperitoneal space. When he opened the uterus up, he observed un-coagulated blood in the uterus, a large amount of blood, and some blood clots on the bottom of the uterus. When he began the hysterectomy, he

observed a large retroperitoneal hematoma from the oozing of the uterus. Because of the location of the hematoma, he had difficulty identifying the left ovarian vein and during the process it was lacerated so he asked the vascular surgeon, who had just finished a case, to scrub in to take over the care of the left ovarian vein. The vascular surgeon clipped the left vein to prevent further bleeding. The patient continued bleeding throughout the surgery and coded three or four times in the operating room, and each time they were able to "bring her back." He closed the patient but she coded one more time so he opened her up again to put more packing in and then closed her again. She was then stable enough for transfer to the ICU to be managed by the cardiologist. Dr. King finished the surgery and left the hospital at approximately 2:00 p.m. He spoke to the patient's parents, her husband was not present (the records indicate he was at the NICU with the twins), he explained what had occurred, and he left the hospital. He returned to his office and continued seeing patients. He did not finish until approximately 6:00 or 7:00 p.m. He then went to the other hospital to check on the other patient at that hospital and later learned that the Victor Valley patient had expired.

144. He did not return to Victor Valley to dictate his operative note. At approximately 9:00 or 10:00 p.m. he went home, and at approximately midnight he dictated the exploratory surgery operative note and "forced myself to sleep" because he needed to move on for his other patients. Dr. King had never had a maternal death; this is the only one he has ever experienced. He is very upset about what happened. In order to prevent it from occurring again, he spent a lot of time getting approval to create an OB/GYN hospitalist program, which he finally succeeded in creating in 2020. The program consists of six OB/GYN's on staff, four of whom participate in the program. Three physicians take approximate five shifts per person; Dr. King does all the rest of the shifts, approximate 15 or 16 days' worth. He does approximately half

the load and has done so since the program began. The reason is because he does not want this to ever happen again.

In addition to physician shortages, the program has an even "bigger problem on the nursing side." There are simply not enough nurses, be it labor and delivery nurses, PACU nurses, floor nurses, or ICU nurses, to treat the amount of patients in the community. In fact, the charge nurse involved in this case died of colon cancer in 2019, which was a tremendous loss to Victor Valley because she was a valuable resource and has not been replaced. They are "constantly fighting" to get enough nurses, but at least now there is a OB/GYN in-house. Dr. King submitted numerous text messages between himself and colleagues corroborating his testimony regarding the medical staffing shortage issues in the community.

145. Dr. King ended his direct testimony by imploring the board to let him complete his mission. He has been a physician for 30 years in California and wants to continue working in the High Desert for another five to seven years. During this hearing he received a text from one of his laborists, who advised that he broke his back so Dr. King will have to work even more shifts. Dr. King explained he cared for this patient to the best of his knowledge, and she was stable when he left Victor Valley. When she was transferred to the floor at 4:30 a.m., if he had ever been called about her unstable condition, he would have immediately taken her to the operating room. When he did learn of her condition, he did all that he could to get her to the OR and he believes that if he had been immediately notified of her condition, she would not have expired. He explained that is why this case makes him so emotional because he believes she could have been saved if her condition was recognized when that occurred on the floor.

146. Also as a result of the accusation, Dr. King took a medical record keeping course which he successfully completed in June 2022. He described the course as "excellent." He reviewed his case with the instructor who advised him to do "defensive charting" and do a more careful care plan and documentation of his thought process and to document the patient's response. The instructor also advised him to document the lack of resource issues he encounters such as shortages of nurses, an inability to get an ICU bed, the experience of the PACU nurse - to document why he does what he does due to the various shortages/limited resources. These tips were extremely helpful and Dr. King has utilized them.

147. Dr. King also testified regarding the FNP allegations. He was advised by his management that the Barstow Women's Medical Center was an entity no longer used, so in 2000 its name was canceled and replaced with Barstow Women's Medical Center, Inc., and the FNP was concurrently updated with the board. That FNP has been current since 2000. The board documents demonstrated that an FNP for this entity was filed on March 8, 2000, and expires on March 31, 2024. The confusion seems to have occurred because when Dr. King's civil litigation attorney notified the board of the doctor's clinics, the attorney left off the "Inc." and the unincorporated entity no longer has an FNP. However, the FNP for the incorporated entity has always been registered with the board, and no evidence contradicted Dr. King's explanation.

148. Regarding the FNP for the High Desert Women's Memorial Medical Center, that name was not listed as one of Dr. King's clinics in the letter his civil litigation attorney sent to the board. Dr. King testified that he has never had a practice under that name, it is his corporation name that he registered with the state and was basically used for his personal business purposes, but he never advertised or put forth any public information regarding that name so, pursuant to the requirements of the

applicable code sections, he did not need to register it as an FNP. However, out of an abundance of caution, after the accusation was filed, Dr. King did obtain an FNP for it even though he does not advertise it, have any signage, or provide any patient care using that name. No testimony was offered refuting Dr. King's testimony about this name or his interpretation of the applicable code sections.

149. On cross-examination, Dr. King testified that given that he first saw the patient at the third trimester, his documentation of her being at 32 weeks or 34 weeks are not contradictory to each other and both are within the acceptable estimated ranges. Dr. King agreed that he did not document the patient was anemic, but her lab values of 9.1 demonstrate that she was, so that fact is in her records. He agreed that when he got the initial call about the patient's condition after he left Victor Valley, he was very concerned, which is why he got a second call from the nurse to advise him of the results of the Rapid Response Team intervention. He ordered the two units of blood and a STAT ultrasound. The first unit of blood was given at 1:15 a.m. Although he ordered a STAT ultrasound, because Victor Valley uses an outside service, it was not performed until several hours later.

150. He kept the patient in the PACU to see how she would react to the blood transfusion and if her condition returned to normal. If so, he would be "pretty sure that the hypertension was caused by her preoperative anemia and estimated blood loss" during the C-section. He was "happy" that the Rapid Response Team could stabilize the patient. He later learned about her incisional pain complaints but was not that concerned as this is normal when the spinal anesthesia wears off. He asked for the charge nurse to assess the patient just to have another evaluation. At this point he was confident the patient was in good hands and doing well.

151. Dr. King received approximately six telephone calls from the nurses at Victor Valley regarding the patient's condition. Dr. King explained that even if he had been present to evaluate the patient, it would not have changed his plan of ordering the two units of blood and an ultrasound. He was also waiting to see how the patient reacted to receiving the two units of blood. The phone calls he was receiving demonstrated the patient was stabilizing, and she was also having physical exams by the PACU nurse and then the charge nurse so there was no more for him to do.

152. Dr. King had just pulled into the Victor Valley parking lot when he got the call about the patient's stable condition, so he took a quick 20 minute nap in his car. When he awoke, he went to the hospital and reviewed the patient's chart. The ultrasound report was still not available, but he had gotten the verbal report. He was finally able to review the ultrasound report at approximately 3:45 or 4:00 a.m. He stayed at the hospital until approximately 4:30 a.m., but is not sure of the times. He was "dead tired" so he was resting in the physician's lounge. He then went to the apartment at his office to rest and immediately returned to the hospital when he was called by the anesthesiologist. He went to the floor to examine the patient and then downstairs to secure an operating room. He gave no additional orders because at that time the patient was being managed by the ICU cardiologist. Dr. King agreed that he did not list amniotic fluid embolism in his operative report, as it is typically a clinical diagnosis made after the patient passes, and because her condition happened so fast; he believed that she may have had an amniotic fluid embolism, but she never had an autopsy to confirm this assumption.

153. Dr. King's testimony at this hearing and during his board interview conflicted with his deposition testimony regarding where he went after delivering the patient's twins. At his deposition, he testified he went home, as opposed to his later

statements were he said he went to another hospital to perform a C-section. At this hearing he explained that following this incident he was "in shellshock," suffering "tremendous mental depression" at the time and even today feels remorseful. As a result, he forgot he went to the other hospital. He explained that following his deposition, when he read a printout of his transcript, he realized his error and notified his attorney, and they were in the process of correcting that statement when the civil litigation settled.

Although complainant asserted that this misstatement undermined Dr. King's credibility, that argument was not persuasive. In civil litigation at the conclusion of taking a deposition, the deponent is advised that he or she will be given an opportunity to review the transcript, make any changes thereto, and certify the transcript under penalty of perjury. Dr. King's explanation of what occurred after reviewing his transcript was consistent with that procedure. Moreover, no copy of Dr. King's certification of his deposition testimony was offered, so nothing contradicted Dr. King's testimony at this hearing about what occurred after his deposition. Moreover, complainant did not charge Dr. King with committing dishonesty and did not investigate to determine if he was delivering a baby at another hospital.

Additionally, Dr. King made errors regarding his estimation of times or distances he traveled. These errors were minor and understandable given that he had been working all day and all night long and was not checking his watch to confirm times. In any event, regardless of where Dr. King went after he left Victor Valley, or what time he arrived at that location, it was established that from the time he left Victor Valley on the night of September 11, 2016, he did not see the patient again until 7:00 a.m. or 7:15 a.m. the next morning when he evaluated her before performing the emergency surgery.

154. Dr. King became extremely emotional when describing this incident and several breaks had to be taken so that he could compose himself to continue. It was clear that this event has profoundly affected him. Moreover, it was also clear that he works in an extremely rural community with limited resources, and that he spends countless hours treating patients in his offices and at the various hospitals where he has privileges. The picture that emerged from Dr. King's explanation of his working conditions was one where very few OB/GYN's treat a large patient population over a vast geographic area, putting in long hours and getting very little sleep, all of which was consistent with a report from the Attorney General report referenced in his attorney's letter to the board. In fact, Dr. King all but apologized for taking a nap in his car when he first returned to Victor Valley at 3:00 a.m. after learning the patient was stable. He appeared both contrite and humble when explaining his need for rest. It was evident how exhausting his work is and yet, how devoted he is to his patients.

Complainant's Expert's Opinions

155. Douglas K. Fenton, M.D., reviewed the records at issue in this case and testified for complainant. His CV listed his education, professional experiences, publication, memberships, awards, professional societies, committee work, quality improvement activities, and the research he has conducted. Dr. Fenton is board certified by the American Board of Obstetrics and Gynecology. He is currently the Medical Director of the OB/GYN Division of Scripps Coastal Medical Center and the Medical Directors of the Maternal Child Health, Advanced Gynecological Surgery, and the OB hospitalist programs at Scripps Memorial Hospital Encinitas.

Dr. Fenton authored a report and on direct examination testified consistent with the opinions expressed in it. However, on cross-examination he withdrew several of his

opinions. It was shown that the basis of his opinion, that the patient bled for hours following her C-section, was unfounded, casting doubt on his opinions overall.

156. Dr. Fenton's report contained two violations of the standard of care that he opined were extreme departures. He opined that Dr. King (1) failed to provide bedside assessment and evaluation and documentation of such assessment and evaluation following Rapid Response and delayed in providing appropriate postsurgical care and (2) had absent and poor documentation. Dr. Fenton offered many opinions while testifying, but only those relevant to the allegations pled in the first amended accusation were considered and are addressed below.

FAILURE TO PROVIDE A PROPER BEDSIDE ASSESSMENT AND EVALUATION FOLLOWING RAPID RESPONSE AND/OR DELAY IN PROVIDING APPROPRIATE POSTSURGICAL CARE

157. Dr. Fenton opined in his report that the patient "experienced hypertension, agitation, restlessness and a significant drop in hemoglobin to 6.4 less than 2 hours after completion of her cesarean section. As the most likely etiology of [the patient's] presentation was postsurgical bleeding (including uterine atony), bedside evaluation, examination, formulation of the differential diagnosis, and a possible return to the operating room at that time is standard of care." Dr. Fenton wrote further:

> [The patient] demonstrated evidence of severe anemia with associated altered vital signs and sensorium. There is no documentation that Dr. King returned to the bedside or designated another covering physician to assess the patient. It was Dr. King's duty to perform a pelvic exam to

> rule out lower uterine segment atony, assess the possible use of uterotonic's [*sic*], and evaluate the need to return to the operating room to identify and control the source of bleeding. Dr. King ordered a blood transfusion over the phone which was reasonable however only has [*sic*] a measure to initiate correction of the severe anemia pending his evaluation. He ordered an ultrasound which was not completed for close to 2 hours after the incident. When patients present with this constellation of signs, symptoms, and laboratory so proximate to the completion of the surgery postoperative intra-abdominal or retroperitoneal bleeding is the leading diagnosis. Despite the lack of significant vaginal bleeding, this does not preclude the presence of a large amount of blood clot in the lower uterine segment or in the fundus of the uterus. This expert reviewer does not concur that the patient experienced an amniotic fluid embolism, but rather succumbed to a coagulopathy related to ongoing, unaddressed postsurgical bleeding. Transfer to the ICU following reexploration for postoperative bleeding would have been appropriate. The patient experienced hours of hypotension, tachycardia, abdominal distention and this delay further complicated her clinical status resulting in cardiovascular collapse.

Dr. Fenton testified that after delivery, the patient became progressively hypotensive but did not reach a critical level until 12:40 a.m., at which point the Rapid Response Team was called. He opined that the patient was in shock, and that she

became extremely restless and agitated which were also signs of shock. He agreed that Dr. King's ordering two units of packed red blood cells was appropriate, but that he should have taken the patient back to the operating room after a thorough bedside physical examination was performed. It appeared the patient was being monitored only by nurses, so it was incumbent upon Dr. King to do a bedside evaluation and look for concealed bleeding, but he acknowledged he did not know the experience of the PACU nurse.

Dr. Fenton opined that even if the Rapid Response Team could temporarily stabilize the patient, as occurred here, it was important to assemble an operating room team, especially as a Rapid Response Team does not typically include an OB/GYN physician. Dr. Fenton opined that the extreme departure from the standard care began at approximately 12:42 a.m. when the Rapid Response Team was called after which Dr. King did not perform a bedside evaluation of the patient. Dr. Fenton opined that Dr. King cannot depend on the emergency room physician, nurses and respiratory care therapist who are members of the Rapid Response Team, who are not surgeons, to perform a bedside assessment of patient, and Dr. King should have done one.

Dr. Fenton did not believe the ultrasound was sufficient to rule out bleeding because it would not be able to detect retroperitoneal bleeding because it was a limited abdominal ultrasound. Dr. Fenton criticized Dr. King for not going to examine the patient after he arrived back at Victor Valley at 3:00 a.m. Dr. King stated in his deposition that he did not see the patient until approximately 7:00 or 7:30 a.m., and Dr. Fenton was critical of this delay. Dr. Fenton opined that a physician in the same or similar circumstances would have gone back to the hospital, attended to the patient, done a history and physical, documented a differential diagnosis, and would have taken the patient back to the OR.

On cross-examination, Dr. Fenton acknowledged that Scripps has a laborist program where an OB/GYN is on call for deliveries and emergency consults. Although he has worked at Scripps since 2009, Dr. Fenton was unable to answer any questions regarding Scripps's operating budget, its number of employees, including OB/GYN's, or its premier status among hospitals in San Diego County. He did acknowledge that Scripps operates four hospitals, and that as the chairman of the OB/GYN department for his group, he oversees approximately 20 OB/GYN's.

Dr. Fenton did not know what resources were available at Victor Valley, and he did not know the number of physicians or OB/GYN's who practice at Victor Valley. He did not know the patient/physician ratio in the High Desert. He did not know if Dr. King practiced in a rural area or if Victor Valley was classified as a rural hospital. Dr. Fenton also did not know if Dr. King practiced in an underserved community and did not know the demographics of the area. Dr. Fenton knew that in 2016 there was not a laborist program at Victor Valley, but there is one now.

Dr. Fenton testified about his review of the documents, agreeing that the medical records are the most important ones to review. He asserted that he took lots of time to ensure that his understanding of the record was accurate as it was his "duty to provide a thorough, independent review of the records," and he carefully reviewed the records. Dr. Fenton was also questioned regarding ACOG guidelines for expert reviewers, and acknowledged they require the expert to the thorough, fair and impartial and not exclude relevant evidence, testifying he would "be happy to have" his report reviewed to demonstrate compliance with those requirements.

Dr. Fenton acknowledged he did not mention in his report that the patient was anemic before the C-section, and he did not know what criteria Victor Valley used for pregnant patients with anemia. He conceded that the patient was stable at 12:15 a.m.,

but he did not document that in his report. His report also did not reference that Dr. King left Victor Valley to attend to another delivery because there was a discrepancy as to whether Dr. King went home or to another hospital. Dr. Fenton also acknowledged that his report did not document that after the patient was transferred to the floor, Dr. King was not notified of any changes in her condition until 6:30 a.m. Dr. Fenton agreed that when Dr. King was notified about the patient's condition he went to the hospital and tried to take her immediately to the operating room. Although Dr. Fenton opined that he could not determine whether the left ovarian vein laceration occurred during the C-section or the hysterectomy, he agreed that the hysterectomy was performed in the area of the left ovarian vein whereas the C-section was not.

Dr. Fenton initially asserted the time frames in his report were accurate. However, when the records were pointed out to him, he conceded that his opinion that the "patient continued to be hypotensive and tachycardic" was inaccurate because the patient was stable during the early morning hours until her condition changed after she was transferred to the floor. In this regard, Dr. Fenton had great difficulty acknowledging his error, which made him appear biased.

When asked about the Rapid Response Team report, Dr. Fenton agreed that they recommended continued monitoring of the patient and did not recommend an evaluation by Dr. King. Dr. Fenton also acknowledged that the patient's pain complaints at 2:00 a.m. were in the area of her C-section incision and were not back pain complaints. He agreed she only complained of back pain right before she coded, but he did not document this in his report. Dr. Fenton agreed the ultrasound did not show significant bleeding and was essentially a normal abdominal ultrasound, but asserted that a large retroperitoneal hematoma cannot usually be seen on an abdominal ultrasound, especially given the patient's bowel distention.

FAILURE TO PROPERLY DOCUMENT THE CARE PROVIDED TO THE PATIENT, INCLUDING PERINATAL CARE AND FOLLOWING RAPID RESPONSE

158. In his report, Dr. Fenton wrote that the standard of care requires a physician to perform and document a history and physical and provide documentation of assessment/plan of care. Operative notes must reflect the operative findings and surgical procedure. Dr. Fenton opined that Dr. King's prenatal record was insufficient and incomplete. "All aspects of his documentation including any bedside evaluation, his operative notes, discharge summary [*sic*] were inadequate by all accepted standards. It was noted in the anesthesia records that the patient received Methergine during the C-section, but there was no mention of this in the operative note. For the reoperation, the anesthesia records reflect that the patient was closed and then reopened for packing. In addition, it was unclear if the retroperitoneal hematoma formed during the hysterectomy or was present upon reoperation. The discharge summary did not articulate care rendered. These departures constitute an extreme departure from the standard of care.[5]

Dr. Fenton found that Dr. King's prenatal records of his office visits with the patient were a "paucity of documentation." He opined the notes were difficult to read and incomplete. He explained that the electronic medical record (EMR) system used by Scripps is a "very robust," a "complex" EMR. He did not have widespread knowledge of other EMR's use in the community and did not know what EMR Dr. King used in his

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[5] Although Dr. Fenton also offered testimony regarding the death certificate and criticized Dr. King's belief the patient may have had an amniotic fluid embolism, complainant did not allege these issues in the first amended accusation and they were not considered in this decision.

office. Dr. Fenton was critical that there was nothing listed on the problem list, and other blank sections included the plans, medications, last menstrual period and an estimated due date. No prenatal lab work was documented and there was no outcome of any of the patient's prior pregnancies. Also, the records were unclear as there appeared to be three visits documented given that there were three entries, but two of the entries were for the same date so it was possible that was just two visits. Dr. Fenton did not know why there was a date of visit for December 19, 2017, when the patient died in September 2016.

Dr. Fenton was critical that Dr. King did not document the Methergine given to the patient during the C-section, although he acknowledged on cross-examination that it was documented in the anesthesia records, but it was not clear who administered the medication. There was also no documentation that Dr. King arrived back at Victor Valley at 3:00 a.m. Dr. Fenton also opined that Dr. King's documentation did not provide enough information to explain why the patient underwent the hysterectomy although he did agree that uterine atony and the patient's vital sign changes would indicate internal bleeding. Dr. Fenton was also critical that Dr. King's operative report was incomplete because the patient was closed initially, then reopened, but this was not clearly documented in the report. Dr. Fenton testified that he could not determine when the retroperitoneal hematoma was present, but based upon the deposition testimony of the attending surgeon, it was present when the abdomen was reopened.

Respondent's Expert's Opinions

159. Howard C. Mandel, M.D., reviewed the records at issue in this case and testified for Dr. King. His CV listed his education, professional experiences, his publications, research and publications, professional societies, advisory committees,

memberships, honors and awards, and recognitions. He is board certified and is a Diplomate of the National Board of Medical Examiners with a lifetime certification, a Diplomate of the National Board of Physicians And Surgeons - Obstetrics And Gynecology, where he is been recertified several times, and a Diplomate of the American Board of Obstetrics and Gynecology, where he is recertified regularly.

He did his residency at Cedars-Sinai Medical Center, where he was the chief resident. He has served on several boards and committees, including the Los Angeles City Health Commission, the National Physicians Council For Healthcare Policy, the UCLA Nursing School Dean's Advisory Board, and has been chief of surgery, chief of gynecology at several hospitals and served on quality care committees. Dr. Mandel was the best medical student at NYU and received an award for the best research paper. He was the best OB/GYN resident graduate. He has held numerous leadership positions, and was recently inducted as a board member of the National Board of Physician and Surgeons, a national leadership role. Dr. Mandel practices at three primary hospitals where he is the Chief of OB/GYN and Chief of Surgery. He has been involved in ACOG activities on a national level, and has testified before Congress on women's health care issues. He is a trustee of Johns Hopkins University. In addition to his practice, he has been doing forensic work since 1985 for both the board and physicians, and donates all of the money he receives for that work to charity.

Dr. Mandel reviewed the documents at issue, had discussions with Dr. King and authored a report. He testified consistent with the opinions expressed in that report at this hearing. Dr. Mandel disagreed with Dr. Fenton's opinions.

160. Dr. Mandel opined that Dr. King appropriately managed this patient pre-delivery. He explained that it is difficult to establish gestational age when a patient presents during the third trimester, as this patient did. At that time there is a wide

standard deviation of plus or minus 15 days when the patient is seen after 18 weeks, and an ultrasound taken after 23 weeks will have a plus or minus three week standard deviation in gestational age. As such, the records documenting the patient was 32 or 34 weeks is within that standard deviation and did not violate the standard of care.

161. When the patient presented at the emergency room, she was in active labor. She had blood drawn at 9:40 p.m. which showed a hemoglobin of 9.1 and a hematocrit of 20.9. To a medical probability, she was dehydrated so she was hemocompromised making her real hemoglobin and hematocrit levels probably less and also women with twins are notoriously dehydrated. Dr. Mandel noted that the estimated blood losses are notoriously inaccurate during a C-section, especially with twins and patients who are hemoconcentrated. The patient was also given "lots of fluids" during the procedure.

Dr. Mandel noted that the anesthesia report documented the Methergine given to the patient, and the patient received 1900 mL of IV fluids during the C-section. The significance of that amount of fluids and her anemia would mean that she would be hemodiluted; because of her dehydration, her hemoglobin and hematocrit would be artificially inflated and adding the IV fluids would decrease those numbers, especially given that she received a spinal block for the C-section which would shift the blood flow to the lower extremities. He explained that because of this, a lot of IV fluids were given to the patient so there will be wide swings in blood pressure, especially with twins. Here, the patient did "beautifully" from 11:00 p.m. to 11:30 p.m. following delivery.

At 1:30 a.m. Dr. King had a delivery in another hospital, something that is not uncommon in rural areas, especially because of the shortage of OB/GYN's. Dr. Mandel stated that 50 percent of counties in the United States do not have an OB/GYN, and it

is not uncommon for an OB/GYN to cover more than one hospital. It was appropriate for Dr. King to leave the hospital to attend to the second patient especially as the Victor Valley patient was "doing excellent." She was at the PACU, and she was stable and doing well. Dr. King made sure the patient was stable before he left.

At 12:40 a.m. the patient's blood pressure was 51/42, which probably occurred because of three significant medical reasons: she had preoperative anemia, she had hemoconcentration, and she had dilution with IV fluids and normal intraoperative blood loss. Summoning the Rapid Response Team was appropriate, and the team was present roughly five minutes after being summoned. The Rapid Response Team managed and addressed the situation and recommended that the patient continue to be monitored in the PACU. Dr. King was notified of the Rapid Response Team call, and he ordered that the patient be transfused with two units of packed red blood cells and observed to see if this was enough to provide equilibration, which would be done by a repeat CBC and hemoglobin and hematocrit four hours after the second unit was completed. The patient was transfused quite rapidly and Dr. King ordered an ultrasound to rule out internal bleeding.

Having reviewed the deposition transcripts and spoken with Dr. King, Dr. Mandel is aware that the PACU nurse is a very experienced nurse who advised Dr. King that the patient's uterus was firm and normal with no active bleeding. Based on these facts, Dr. King acted appropriately and within the standard of care.

The records showed that although the patient was being examined, there were no entries in the record until 3:46 a.m. so the nurse's findings were not available for anyone else to see but she was advising Dr. King of the patient's condition by telephone. The PACU nurse was evaluating the patient every 10 to 15 minutes and all of her vital signs and examination results were normal. At 2:00 a.m. the PACU nurse

spoke with Dr. King and advised him the patient was having pain at her incision. Dr. Mandel explained that this would be the approximate time that the spinal anesthesia would have worn off, so it was normal the patient had a pain complaint at this time and Dr. King appropriately ordered pain medication. The ultrasound still had not been performed but, when it was performed at 3:18 a.m., it was normal. Dr. Mandel testified that had the left ovarian vein been cut during the C-section, the bleeding would have been visible on the ultrasound and it was not which proves that the laceration of the left ovarian vein occurred during the hysterectomy. Dr. Mandel opined that if the patient's pain was caused by bleeding, it would have been seen on the ultrasound and it was not.

Dr. King returned to the hospital later that morning and was in contact with the nursing team and obtained the ultrasound results. Between 2:30 a.m. and 3:45 a.m. the patient was stable and Dr. King was aware of her condition because the PACU nurse relayed it to him. Dr. King then took a short 20 minute nap. He then reviewed the ultrasound report, the patient's vital signs and other records. He was at the hospital for about one hour and then decided to go to his office which is three minutes away to take a nap. He chose to go to his office and not to his home, which is 35 minutes away, in case he was needed at the hospital for the patient, and he had to start his office hours in a few hours.

Dr. Mandel disagreed with Dr. Fenton's opinion that it was an extreme departure from the standard of care not to perform a bedside evaluation after the Rapid Response Team treated the patient. There was an experienced PACU nurse monitoring the patient, who had worked with Dr. King for years, whom he knew very well and whose assessments he could trust. Dr. Mandel explained the team concept of hospitals, and how it is within the standard of care for physicians to rely on reports

from nurses and other physicians. Here, the patient's vital signs were stable, her uterus was firm and at the right location, there was no lochia, and the ultrasound was normal. If Dr. King had performed a physical examination this would not have changed the patient's management whatsoever. At 3:18 a.m., a retroperitoneal hematoma would have been present on the ultrasound if there was one, and there is no medical probability that it would not have been visible had it existed, so had Dr. King performed a physical examination after the ultrasound, there would be no hematoma to feel. Moreover, it would not be possible to feel a retroperitoneal hematoma on a postpartum woman four and one-half to five hours after delivery; in fact, a retroperitoneal hematoma is impossible to feel on an anorexic woman, so a physical exam by Dr. King on this patient would add nothing to the plan.

Dr. Mandel opined that Dr. King met the standard of care with his monitoring of the patient following delivery and following the Rapid Response Team intervention.

After the patient was transferred to the floor between 4:30 and 4:40 a.m., she was observed by the floor nurse. Based on his review of the records, he believes what happened was that the patient started to bleed at that time and two things happened: her vital signs became unstable and her uterus elevated because the mass began to develop underneath. This is why her fundal height rose to three fingerbreadths. Unfortunately, the floor nurse did not recognize that an increasing fundal height was a very dangerous condition and did not notify anyone of it or call the Rapid Response Team. The floor nurse did not notify Dr. King of that very significant clinical finding. In her deposition, the floor nurse testified that the three fingerbreadths height was normal, but it is not; it was grossly abnormal and, more importantly, a significant clinical change in this patient's presentation.

When Dr. King was ultimately notified of the patient's changed condition, it was because the anesthesiologist did a postop checkup of the patient before leaving the hospital, discovered her condition, was concerned about those clinical findings, and called Dr. King, who immediately returned to the hospital.

Dr. King wanted to take the patient to the operating room immediately, but Victor Valley is a small rural hospital with only four operating rooms and all of them were in use. So Dr. King spoke to the "significant nursing administrators" and mobilized a transfer to the ICU temporarily until an operating room was available so he could perform surgery as soon as possible. The patient was under the care of both the cardiologist and two anesthesiologists, and it was appropriate for Dr. King to defer to them while he was trying to get an operating room opened. Dr. King knew those physicians were used to handling patients with wide swings of blood pressure and if the patient had an amniotic fluid embolism, the literature indicates that the intensivists should handle that condition. So deferring to those physicians while attempting to obtain an operating room met the standard of care.

Dr. Mandel explained uterine atony, describing how the uterus contracts to stop bleeding post-delivery. But if the uterus does not contract, blood will start pouring from the uterus. This will cause the uterus to expand which is why the patient's fundal height was three fingerbreadths. When respondent was finally able to take the patient to surgery, he appropriately addressed her condition, but by then she was quite acidotic and hypotonic so those efforts were not enough to save her life.

Dr. Mandel disagreed with Dr. Fenton's opinions regarding the hysterectomy operative report. Dr. Mandel testified that the emergency hysterectomy performed was appropriate and easily understood by reviewing the records. Dr. King wanted to take the patient to surgery at 7:00 a.m. but was unable to do so and reacted as quickly as

possible under the circumstances presented. As soon as he was notified of the patient's changed condition, he did all he could as soon as possible given the limits of a rural hospital. Dr. King provided excellent medical care whenever he was given accurate information.

162. Dr. Mandel also offered opinions regarding Dr. King's prenatal care of the patient. She came to him late in her pregnancy, during her third trimester. Dr. King's records documented all the pertinent information at that time, and he requested the records from the patient's prior OB/GYN so he could fill in the data on his records from those records, which was appropriate. The information Dr. King did place in his records was excellent and within the standard of care.

The records accurately reflect the two dates that Dr. King saw the patient. Dr. Mandel does not know how the December 19, 2017, date got on the record. However, the records document the office visits and no one reviewing the records would be confused. Dr. King appropriately referred the patient to a maternal-fetal specialist given her advanced maternal age and twin pregnancy. Dr. Mandel opined that the records meet the 2016 standard of care.

Dr. Mandel also offered opinions regarding the hospital records. He believed Dr. King's records met the standard of care. Reviewing the records, one can tell what was happening at Victor Valley. Moreover, based upon all the documents that Dr. Mandel reviewed, he is aware that Dr. King has an excellent reputation in the community, and that his documentation was peer-reviewed by the hospital, and it was determined that his treatment and documentation met the standard of care. Dr. Mandel opined that this is an unfortunate case because the floor nurse did not notify Dr. King, and there was a two and one-half to three hour delay regarding the patient's changed condition which ultimately led to her death.

163. On cross-examination, Dr. Mandel explained that he has lots of experience and familiarity with different EMR's, so is aware of auto population issues and systems that do not know how to handle information so those systems will jump to a second line, which explains why there are two entries for one visit because the twins were in different presentations. Dr. Mandel does not believe that the 2017 entry has anything to do with when the document was created, he believes it occurred when the document was copied or printed out which would be consistent with the timeframe of the civil litigation.

Dr. Mandel acknowledged that an amniotic fluid embolism is rare but noted that Dr. King did not diagnose one before surgery. He agreed that a postpartum hemorrhage is more common with twin gestation but disagreed that estimating the gestation at 32 or 34 weeks would change how the patient was managed. He agreed that at 12:40 a.m. the patient had been experiencing a slow contiguous decrease in blood pressure, and that her 6.4 hemoglobin was a "really concerning number." He noted that it is unknown whether her hemoglobin at the PACU resolved above 6.9 because she was given a blood transfusion and not enough time elapsed for co-equilibration to occur as the plan was to give her two units of blood then wait several hours and repeat the labs.

Dr. Mandel opined that the ultrasound was the proper test to order to reliably detect retroperitoneal bleeding, and he is unaware of any literature that requires anything more than an ultrasound be ordered, as was done here. Dr. Mandel explained that an ultrasound is utilized for the initial evaluation of intra-abdominal or retroperitoneal bleeding. The ultrasound ordered here is highly accurate in detecting retroperitoneal bleeding and did not show such. Dr. Mandel believes the retroperitoneal hematoma formed after a period of time, in all medical probability

between 4:30 a.m. and 6:30 a.m., which was the time during which her uterus got bigger, and her clinical situation and vital signs worsened, and she had abdominal distention.

Dr. Mandel believes that the floor nurse violated the standard of care for nurses because there were clinical symptoms and findings that were dramatically abnormal and are not what is seen in a normal post C-section delivery. As such, the nurse should have notified someone of these findings, but did not. Dr. Mandel opined that the patient's change in condition between 4:30 a.m. and 6:30 a.m. was unrelated to the 12:40 a.m. Rapid Response Team intervention. The 12:40 a.m. presentation was related to the patient's severe anemia or the spinal anesthesia given that can alter blood pressure and places fluid and blood flow to the lower extremities and is the blood pressure that occurs after delivering twins. Furthermore, the ultrasound ruled out bleeding, making it more likely that she began losing blood after being transferred to the floor. Moreover, while at the PACU, that nurse repeatedly documented small vaginal bleeding, which would be a normal finding, further supporting that the bleeding did not occur in PACU. In addition, when the patient's condition on the floor was initially discovered, the ICU cardiologist was contacted, not Dr. King, which further delayed his being notified of the patient's changes.

Even if respondent had not had to deliver a baby at another hospital, he did not have to remain at Victor Valley. The patient was stable at 11:30 p.m. and doing well in the PACU. It was okay at that point for him to leave. Moreover, Dr. King was well aware of the PACU nurse's level of experience, having worked with her for several years. Her deposition testimony set forth her extensive training and experience, including having been a licensed nurse since 1981 with 12 years of ICU experience prior to working at

Victor Valley. She is also a certified critical care nurse so would have experience in giving blood transfusions.

Dr. Mandel's understanding of the facts is that when Dr. King returned to the hospital after delivering the other baby, he was in his car when he was called and advised of the patient's stable condition. He then took a 20 minute nap in his car after which he went into the hospital and checked the ultrasound and the labs and went to the physician's lounge. Doing this did not violate the standard care because Dr. King had a PACU nurse he trusted, who reported the patient was stable, the Rapid Response Team had evaluated the patient and felt she was stable, the second unit of blood was going in and he was waiting for the second labs to be drawn.

Furthermore, the patient was sleeping and knowing that she had just delivered twins, it was reasonable to allow the patient to sleep and knowing that Dr. King's office hours began in a few hours, and he had responsibilities to other patients, it would be prudent for him to take a nap. Also, the ultrasound was normal so there was no reason to take the patient to surgery. Dr. Mandel disagreed with Dr. Fenton that other physicians should have been made aware that Dr. King was back at the hospital or that he needed to document such in the records. However, Dr. Mandel pointed out that there would be an audit trail in the electronic medical records regarding Dr. King's review of the ultrasound and chart which is the purpose of an audit trail. Of note, complainant did not obtain or introduce an audit trail at this hearing so no evidence contradicted Dr. King's claim that he reviewed those records when he returned to Victor Valley.

Dr. Mandel also noted that Dr. King practices in a rural area with approximately 250,000 patients, who live over the wide geographical area, it is "a massive valley." Victor Valley only has four operating rooms and when all of them are being used, as

was the case here, they do not have a "swing room" that could be used as an operating room. As such, Dr. King's only option was to send the patient to ICU, but that unit only had 11 beds.

Dr. Mandel acknowledged that Dr. King's documentation of the exploratory surgery "could have been better," but he had only slept a couple hours, the patient had already expired, and this was the last report he was entering in the chart. Further, Dr. King saw patients in his office after this surgery. Although Dr. Fenton noted that the document was created the next day, it was actually created at 12:07 a.m., just seven minutes after the day the patient died. In any event, the report met the standard of care and was "adequate enough" for a reviewer to tell what Dr. King did.

Character Witnesses' Testimony and Letters of Support

164. Vijay Arora, M.D., wrote a letter of support for Dr. King and testified in this hearing consistent with his letter. His CV was also introduced. Dr. Arora is a board-certified OB/GYN and fellow of ACOG and the American College of Surgeons. He is also a member of the Royal College of Obstetricians and Gynaecologists in London. Since 1985 he has had a private OB/GYN practice in Apple Valley with privileges at several hospitals including Victor Valley. He did his OB/GYN residency at Albert Einstein University in New York where he was the chief resident and he was the valedictorian of his medical school class. He is an assistant professor of OB/GYN at University of Southern California. He has been the chief of staff at Victor Valley and now serves on the hospital's Board of Directors where he is chairman of the OB/GYN department. Dr. King is the former chairman and is now vice chairman. Dr. Arora has known Dr. King for approximately 30 years.

Dr. Arora has observed Dr. King in the operating room, where he has worked with him. He has shared call with Dr. King, and gotten good feedback from his patients about Dr. King. Dr Arora is familiar with Dr. King's practice from Dr. Arora's work as the department chair because they review the quality of care all physicians in the department and he has gotten positive feedback regarding Dr. King's excellent care, and there are no complaints against him. Dr. Arora is "constantly amazed" that while providing excellent care and compassionate care, Dr. King can also reduce his C-section rate, something Dr. Arora is unable to do. Dr. King's care of Dr. Arora's patients has been outstanding. In his administrative roles, Dr. King also demonstrates excellent leadership, he interacts very well with others. He described Dr. King as very intelligent, very well trained, an excellent surgeon, who has very good interpersonal relationships and the very best care is provided by him under very challenging circumstances. His services are invaluable to the community.

Dr. Arora explained that the biggest complaint at Victor Valley is the "gross deficiency in staffing." There are not enough nurses, not enough staff, not enough operating rooms in house, and the "danger" period at the hospital is the nighttime when things "uniformly happen" during "the danger period" from 11:00 p.m. to 7:00 a.m. These are issues that they are constantly trying to address. They have "a gross deficiency in coverage" because they do not have enough staffing in-house, and the problem in the labor and delivery department is pervasive, especially if C-sections are involved. Owing to the staff shortages, there have been maternal and infant deaths. During the evenings, the operating crew is not in the hospital and valuable time is lost trying to assemble a team, resulting in death. This is an ongoing battle that they all have to fight. Dr. Arora explained how it is virtually impossible to recruit physicians to the community. His daughter, a recently hired physician, is the only new physician in the last 20 years. Before her, Dr. King was the youngest OB/GYN on staff.

Victor Valley and Apple Valley are in the High Desert, a "health care deficient area," a "very underserved area," where it is hard to find medical staff. Victor Valley disproportionally services the underserved, treating approximately 500,000 people. The biggest issue for the rural community is the lack of a support team such as nurses and OR technicians. Because the hospital has such a hard time recruiting staff, the biggest challenge is having nurses on the floor and labor and delivery nurses. Being that Victor Valley is in a rural location, it does not have access to advanced care for anything beyond basic care. There is no neonatal intensive care unit and no advanced specialists. Those services are located approximately 40 miles away at Loma Linda University Medical Center.

There has been an inability to recruit or retain staff because of the lack of amenities that go along with an urban setting such as shopping, theaters, and restaurants. While the hospital does have basic services, it does not have those that are "required very, very often." In addition to being a rural area, the population is spread over quite a large area. Dr. Arora disagreed with complainant's assertion that the community is urban, testifying that the schools, stores, and restaurants are basic essential services and that the median income rates of the community are quite low with 60 to 70 percent of the population being Medi-Cal recipients.

Dr. Arora testified that, unfortunately, the patient's death was due in large part to the lack of staffing which is an unfortunate trend that has continued because they have been unable to attract or retain staff and there is "a tremendous gap" in the resources that are required to provide adequate care. The physicians are trying, but can only do so much and must rely on information communicated to them as they work as a team. Dr. Arora described the situation as akin to "Russian Roulette" and another physician will be in Dr. King's position tomorrow.

In his leadership role, Dr. King created the laborist program. Dr. Arora explained how in order to find continuous care, Dr. King set up a 24 hour laborist program. Dr. King staffs approximately 50 percent of the shifts in the program. As Dr. Arora said, Dr. King "walks the walk, he is in the trenches." Dr. King performs 50 percent of the OB/GYN care in the community. Without Dr. King, the laborist program would collapse.

165. Rahul Nayyar, M.D., wrote a letter in support of Dr. King, testified in this hearing, and a copy of his CV was received in evidence. His testimony was consistent with his letter. Dr. Nayyar is a board certified radiologist. He was chief resident and graduated with honors. He serves on several committees at Victor Valley, including the utilization review committee, as well as a quality monitoring committee for a community health plan.

Dr. Nayyar has known Dr. King since 2016 when he came to Victor Valley and has worked very closely with him. They have worked together providing patient care, and on an administrative level. Dr. King cares about his patients, and they all speak very highly of him. He is well-liked and well received at Victor Valley. The physicians share common nurses and OR staff, and they all talk highly of Dr. King. In his administrative role, Dr. Nayyar sees all the complaints that come to the committee and he has never once seen a write up about Dr. King.

Without Dr. King and his commitment to the program, Victor Valley would not be able to provide a laborist program. Dr. Nayyar explained that the High Desert is an underserved area and they have been trying to recruit staff to the hospital for as long as Dr. Nayyar has been in the community. Most physicians in the community have been practicing there for the past 30 years, and it is hard to convince new physicians to move to the area. As a result, Dr. King takes the majority of the laborist calls which

is the only way they can run the program. Dr. Nayyar has had no luck recruiting physicians.

Given their location, "it is very, very challenging" to recruit physicians. Dr. King is "a staple." He is very critical to keeping the OB/GYN program going. He has been very instrumental in recruiting staff and physicians to the area, and keeping the OB/GYN department and the women's health department going.

166. Julius Cruz, M.D., authored a letter to the board in support of Dr. King. He has known Dr. King for over 27 years and has been the main surgeon to assist Dr. King. He wrote that Dr. King "is one of the most competent [OB/GYN's] I have been working with during my entire professional career." He noted that because Victor Valley is a small rural hospital and there are not enough general surgeons to assist, often Dr. King must do surgery alone, especially after hours but "has demonstrated excellent surgical skills and profound knowledge in all cases" in which Dr. Cruz has been involved. Dr. Cruz has been serving his position in the community for almost 50 years and believes he has "more than enough authority to comment on Dr. King's priceless value to our community and hospital." He described Dr. King as a "great asset" and that the community needs his "expertise to care for our small, underserved community. Dr. King's service is necessary for our understaffed hospital." He strongly supports Dr. King and is happy to answer any questions the board may have.

167. Mukesh Patel, M.D., authored a letter to the board in support of Dr. King. He was the cardiologist involved with the patient's care and gives his "full support" to Dr. King. Dr. King treats many high-risk patients and frequently consults with Dr. Patel and the two often work as a team, especially when patients needed admission to the ICU. Because of his close working relationship, Dr. Patel has been "able to observe in the firsthand Dr. King's unwavering care for his patients in the hospital day in and day

out." He is "impressed not only by Dr. King's outstanding knowledge and surgical care in the OB/GYN but more importantly, he always knows when to call for additional help from his colleagues." Dr. King provides "excellent care to the much-needed underserved community" and Dr. Patel asked the board to continue allowing Dr. King to serve to provide care especially given the scarcity of medical providers in the community. Dr. Patel invited the board to contact him with any questions.

168. Ashley Mora authored a letter to the board in support of Dr. King. She has known Dr. King for more than 25 years and he is "a well known obstetrician in our community and has delivered many children for [*sic*] all walks of life. Dr. King is highly regarded by his patients as a hard-working physician and always puts his patients first ahead [of] everything else." Ms. Mora and her husband "have the fortune to witness Dr. King's dedication to patient care in person." Dr. King cared for Ms. Mora's mother-in-law and delivered Ms. Mora's husband. Twenty-two years later, Dr. King delivered two of Ms. Mora and her husband's children, guiding her through a very difficult pregnancy and delivering "two very beautiful children." Ms. Mora and her husband offered to testify if need be.

169. Tessie Deal authored a letter to the board in support of Dr. King. Ms. Deal is a patient of Dr. King's, and wrote that he "is the best obstetrician here in the high desert community." He delivered all four of her children by C-section and is "regarded one of the best obstetrician and surgeon [*sic*] in town, especially for high risk pregnancy." Ms. Deal recommends Dr. King's "outstanding care and surgical skill" without any reservation.

170. Roxana Alarcon authored a letter to the board in support of Dr. King. She was the obstetric technician involved in this patient's care. She has known Dr. King since 2007 and wrote he is "one of the busiest obstetricians in our department."

During the past 15 years she has assisted Dr. King "for more than thousands of delivery [*sic*] and hundreds of cesarean sections." Based on her observations, "Dr. King is a very skillful surgeon and of all procedures, I am especially impressed by his cesarean section because it is always neat, clean and proficient." She wrote (errors in original), that Dr. King "also has good bedside manner to his patients and is very attentive to patient needs, regardless of time of day. Very often, it is only Dr. King and I that were operating during numerous early morning hours without assistant surgeon because there were not enough obstetricians or surgeon available in the hospital." In addition, despite his busy schedule, Dr. King always spends time with nurses and technicians to educate them and keep them up-to-date on patient care. He provides exceptional leadership, and she is happy to answer any questions about him.

171. Maria Griego authored a letter to the board in support of Dr. King. She is a patient of Dr. King's who has known him for more than 20 years from both of her pregnancies. Dr. King "was always patient and tended to my needs during the pregnancy. I was especially impressed that Dr. King was taking care of his wife's pregnancy at the same time with my first pregnancy. It was at this time that I realized I have a great doctor to take care of me." She still remembers what Dr. King told her during one of her first prenatal visits: that he takes care of patients the same way he takes care of his family which is why he delivered all of her children and all of her grandchildren. She is happy to answer any questions regarding Dr. King.

Costs of Enforcement

172. Complainant seeks recovery of enforcement costs of $24,037.50 pursuant to Business and Professions Code section 125.3. In support of the request, the Deputy Attorney General who prosecuted the case signed a declaration requesting costs for legal work billed through August 12, 2022.

173. Attached to the declaration was a document entitled "Costs of Suit Summary." The document identified the tasks performed, the dates legal services were provided, who provided the services, the time spent on each task, and the hourly rate of the individuals who performed the work.

174. California Code of Regulations, title 1, section 1042, subdivision (b), requires that any declaration seeking costs include "specific and sufficient facts to support findings regarding actual costs incurred and the reasonableness of the costs." The declarations with the attachments for the costs complied with the regulation and those costs of $24,037.50 are found to be reasonable.

175. No evidence regarding Dr. King's ability to pay costs was offered.

The Medical Board's Disciplinary Guidelines

176. Official Notice was taken of the board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (12th Edition 2016).

Closing Arguments

177. Complainant argued that although there was a lot of documentation, details and witness testimony, there needs to be a refocus on what the case is about, a young mom died and left seven children behind after delivering twins at Victor Valley. However, while that is certainly tragic, patient outcome is not necessary to impose discipline (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th757, 772), but may be considered in determining discipline as allowed by California Code of Regulations, title 16, section 1360.1.

Complainant argued that Dr. King attempted to deflect responsibility on the nurses and hospital resources. Complainant asserted that there were early warning

sign of the patient's deteriorating condition, her blood pressure was consistently dropping, her hemoglobin levels were low and she had pain complaints. Dr. King should have evaluated the patient at bedside, especially when he returned to Victor Valley. Complainant also asserted there were major credibility issues regarding Dr. King's testimony because it differed from his deposition testimony. Complainant acknowledged that Dr. Fenton was "not perfect," but he hit home with the central crux of the case, which was that Dr. King failed to recognize a patient who was critically ill and in shock. Dr. King should have examined the patient after the Rapid Response Team intervened and the standard care had already been breached well before the patient was transferred to the floor. Complainant argued that what occurred after that transfer was a "red herring" because the extreme departure from the standard of care had already taken place.

Moreover, Dr. King's documentation was so lacking that it constituted an extreme departure from the standard of care, noting that his office notes, hospital notes, second operative report, and death certificate were inadequate/inaccurate. Complainant argued that Dr. King cannot have it both ways: he cannot argue that there are limited resources and at the same time argue that he relied on the PACU nurse and Rapid Response Team to evaluate the patient. Complainant argued that the evidence speaks for itself regarding the FNP violations. Complainant requested that discipline be imposed consistent with the board's disciplinary guidelines.

178. Dr. King argued that Dr. Fenton was wrong or had an incomplete understanding of the standard of care because he did not take the "same or similar circumstances" portion of the definition into account. Dr. King argued that this case needs to be evaluated under the circumstances that were present and that both Dr. King and Dr. Mandel were able to thoughtfully explain the reasonableness of the care

Dr. King provided. Dr. King asserted that Dr. Mandel was an exceptionally qualified expert who was a more reliable expert, especially as he donates his earnings to charity. While Dr. Fenton's credentials were excellent, his assumptions were factually incorrect, making his opinions unreliable. Dr. King argued that Dr. Mandel had correctly understood the facts and rightly considered the circumstances in which Dr. King practiced, making his opinions more reliable than those offered by Dr. Fenton. Dr. King also noted that his character witness, Dr. Arora, provided profound testimony regarding the limits of working in a rural hospital in a rural community, and the limitations that the physicians face in the circumstances.

Dr. King asserted that he has worked tirelessly to provide excellent patient care in an underserved community. The public would be harmed if he were disciplined because he performs more than half of the OB/GYN care in the High Desert. While this may be true, the goal of discipline is to protect the public and prevent future harm. (Business and Professions Code section 2229; *Griffiths, supra.*) Dr. King asserted that his care and treatment of this patient, as well as his documentation, met the standard of care. He argued there were no FNP violations, because one clinic had always been properly permitted and the other name was not a clinic, and he had never advertised or held that name out to the public, so did not need an FNP. However, out of an abundance of caution, Dr. King obtained one after the accusation was filed. Given that there were no violations sustained, Dr. King requested that no discipline be imposed.

LEGAL CONCLUSIONS

Purpose of Physician Discipline

1. The purpose of administrative discipline is not to punish, but to protect the public by eliminating those practitioners who are dishonest, immoral, disreputable or incompetent. (*Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.)

2. Business and Professions Code section 2229 states: "Protection of the public shall be the highest priority" for the medical board."

The Burden and Standard of Proof

3. Complainant bears the burden of establishing that the causes pled in the accusation are true. (*Martin v. State Personnel Medical Board* (1972) 26 Cal.App.3d 573, 582.)

4. The standard of proof in an administrative action seeking to suspend or revoke a physician and surgeon's certificate is "clear and convincing evidence." (*Ettinger v. Medical board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.

5. Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.) The requirement to prove by clear and convincing evidence is a "heavy burden, far in excess of the preponderance sufficient in most civil litigation. [Citation.]" (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.) "The burden of proof by clear and convincing evidence 'requires a finding of high

probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind.' [Citation.]" (*Ibid.*)

Applicable Code Sections

6. Business and Professions Code section 2227 authorizes the board to discipline a licensee.

7. Business and Professions Code section 2234 states in part:

> The medical board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> [¶] . . . [¶]
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

8. Business and Professions Code section 2266 provides:

> The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

9. Business and Professions Code section 2285 states in part:

> The use of any fictitious, false, or assumed name, or any name other than his or her own by a licensee either alone, in conjunction with a partnership or group, or as the name of a professional corporation, in any public communication, advertisement, sign, or announcement of his or her practice without a fictitious-name permit obtained pursuant to Section 2415 constitutes unprofessional conduct.

10. Business and Professions Code section 2415 states in part:

> (a) Any physician and surgeon . . . who as a sole proprietor, or in a partnership, group, or professional corporation, desires to practice under any name that would otherwise be a violation of Section 2285 may practice under that name if the proprietor, partnership, group, or corporation obtains and maintains in current status a fictitious-name permit issued by the Division of Licensing.

Case Law Regarding Standard of Care

11. The standard of care requires that physicians exercise in diagnosis and treatment that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by members of the medical profession under similar circumstances. The standard of care is a matter peculiarly within the knowledge of experts; it presents the basic issue in a malpractice action and can only be proved by their testimony, unless the conduct required by the particular circumstances is within the common knowledge

of the layman. (*Williamson v. Prida* (1999) 75 Cal.App.4th 1417, 1424; *Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal. 4th 992, 1001.)

12. The standard of care involving the acts of a physician must be established by expert testimony. (*Elcome v. Chin* (2003) 110 Cal.App.4th 310, 317.) It is often a function of custom and practice. (*Osborn v. Irwin Memorial Blood Bank* (1992) 5 Cal.App.4th 234, 280.)

13. At one time, the standard of care required that a physician have the degree of learning and skill ordinarily possessed by practitioners in the same locality. But later the California Supreme Court formulated the standard of care as that of physicians in similar circumstances rather than similar locations. (*Borrayo v. Avery* (2016) 2 Cal.App.5th 304, 310.)

14. Geographical location may be a factor considered in making that determination, but, by itself, does not provide a practical basis for measuring similar circumstances. (*Avivi v. Centro Medico Urgente Medical Center* (2008) 159 Cal. App. 4th 463, 470.)

15. The essential factor is knowledge of similarity of conditions; geographical proximity is only one factor to be considered. (*Sinz v. Owens* (1949) 33 Cal.2d 749, 756.)

Case Law Regarding Negligence

16. A physician is not necessarily negligent due to every "untoward result which may occur." (*Norden v. Hartman* (1955) 134 Cal.App.2d 333, 337.) A physician is negligent only where the error in judgment or lack of success is due to failure to perform any of the duties required of reputable members of the medical profession

practicing under similar circumstances. (See *Black v. Caruso* (1960) 187 Cal.App.2d 195, 200-202.)

17. So far as the phrase has any accepted meaning, "gross negligence" is "merely an extreme departure from the ordinary standard of care." *(Franz v. Medical Board of Medical Quality Assurance* (1982) 31 Cal. 3d 124, 138, citing *Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196 and *Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941.)

18. Courts have defined gross negligence as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Medical Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care. (*Id.* at 1054).

19. A repeated negligent act involves two or more negligent acts or omissions. No pattern of negligence is required; repeated negligent acts means two or more acts of negligence. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468.)

Case Law Regarding Expert Testimony

20. In determining the weight of each expert's testimony, the expert's qualifications, credibility and bases for the opinions were considered. California courts repeatedly underscore that an expert's opinion is only as good as the facts and reason upon which that opinion is based: "Like a house built on sand, the expert's opinion is no better than the facts on which it is based." (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923.)

21. An expert's failure to consider all of the facts may make his opinions less persuasive (*People v. Coddington* (2000) 23 Cal.4th 529, 614) and the expert may be examined about whether the expert sufficiently took into account matters arguably inconsistent with the expert's conclusions. (*People v. Ledesma* (2006) 39 Cal.4th 641, 695.) An expert's opinion may be rejected if the reasons given for it are unsound. (*Kastner v. Los Angeles Metropolitan Transit Authority* (1965) 63 Cal.2d 52, 58.)

Evaluation of First Cause for Discipline: Gross Negligence

22. When evaluating the experts' opinions, it is found that while Dr. Fenton was eminently qualified, his opinions were based on his erroneous conclusions that the patient "continued to be hypotensive and tachycardic despite the blood transfusion," and that she continued bleeding following the C-section. The patient's condition stabilized until she was transferred to the floor, at which time she had significant abnormal changes that the floor nurse did not recognize or report. Dr. Fenton's report never referenced that the patient's condition was stable for several hours or that Dr. King was not notified when her condition became unstable after she was transferred to the floor. Dr. Fenton also demonstrated an inability to acknowledge his mistakes when presented with them at this hearing. As such, his opinions were less reliable than those offered by Dr. Mandel.

The circumstances in which Dr. King practiced must also be considered. It is not just the rural nature of Dr. King's practice, but also that in 2016, there was no in-house laborist at Victor Valley, and Dr. King covered OB/GYN cases at several other hospitals. The physician on the Rapid Response Team at Victor Valley was the emergency room physician, and physicians at Victor Valley reasonably relied on the assessments performed by that physician. Given the staffing issues at Victor Valley, Dr. King reasonably relied on reports from other nurses and physicians regarding the patient's

condition. As Dr. Mandel credibly explained, hospitals work as a team, and it is within the standard of care for a physician to rely on reports from other physicians and nurses, as Dr. King did here.

Dr. Mandel's opinions were based on the facts as set forth in these records and, on balance, his opinions were more reliable, reasonable and persuasive than Dr. Fenton's opinions. It was not necessarily consistent with the standard of care that Dr. King conduct a bedside assessment of the patient after the Rapid Response Team intervened and he did not delay providing postsurgical care. Dr. King's actions and his telephone orders met the standard of care. His reason for not examining the patient when he returned to Victor Valley at approximately 3:00 a.m. was reasonable and was not required given the patient's vital signs and ultrasound results. Given her condition at that time, a bedside assessment was not necessary and not doing one was within the standard of care. Further, Dr. King properly documented the record consistent with the standard of care for record keeping. Based upon the evidence presented here, Dr. King's actions and documentation were reasonable, prudent, and within the standard of care.

GROSS NEGLIGENCE NOT ESTABLISHED

23. Complainant did not prove by clear and convincing evidence that Dr. King was grossly negligent in his care and treatment of the patient in violation of Business and Professions Code section 2234, subdivision (b). Dr. King's assessment and evaluation of the patient after the initial Rapid Response Team intervention met the standard of care. Dr. King did not delay in providing appropriate post C-section care to the patient. Dr. King's documentation of the care provided to the patient met the standard of care.

Evaluation of Second Cause for Discipline: Repeated Negligent Acts

24. The allegations regarding repeated negligent acts were based on the same facts asserted for the allegations that Dr. King committed gross negligence. Given that Dr. King did not violate the standard of care, there can be no finding that he committed repeated negligent acts.

REPEATED NEGLIGENCE NOT ESTABLISHED

25. Complainant did not prove by clear and convincing evidence that Dr. King was repeatedly negligent in his care and treatment of the patient, in violation of Business and Professions Code section 2234, subdivision (c). His care, treatment and documentation thereof met the standard of care.

Evaluation of Third Cause for Discipline: Inadequate Records

26. Complainant alleged that Dr. King failed to maintain adequate and accurate records. Dr. King's explanations for the few de minimis typos in his records and for how his EMR system works was reasonable and unrefuted. Dr. Mandel's opinion that, when reviewing the records, it was easy to understand what treatment Dr. King rendered to the patient, was supported by the evidence. While it is true that the hysterectomy operative report could have been written clearer, it was not written in such a way that it was difficult to decipher what occurred, especially when reviewed in the context of the entire hospital chart. Moreover, any issues Dr. King may have had with his 2016 records was addressed when he took the 2022 medical records keeping course offered by UC Irvine, and no evidence refuted his testimony regarding what he learned from that course or the changes he has since made.

FAILURE TO MAINTAIN ADEQUATE AND ACCURATE RECORDS NOT ESTABLISHED

27. Complainant did not prove by clear and convincing evidence that Dr. King failed to maintain adequate and accurate records in violation of Business and Professions Code section 2266.

Evaluation of Fourth Cause for Discipline: FNP Violations

28. The Barstow Women's Medical Clinic was originally an FNP and later incorporated and a new FNP was obtained. Dr. King's civil litigation attorney failed to include the FNP in the letter provided to the board identify Dr. King's clinics which appears to have resulted in the incorrect assumption that Dr. King operated this clinic without the appropriate FNP. No evidence refuted Dr. King's explanation regarding this clinic, and there was no showing that there was any violation regarding this clinic.

29. The High Desert Women's Memorial Medical Center was the name of the corporation that Dr. King registered with the state and was never a name of one of his clinics. He never advertised or publicly promoted that name, and there was no evidence that he ever practiced under it. As such, an FNP was not required, although, out of an abundance of caution, and to demonstrate his willingness to comply with any board requirements, he obtained an FNP after he was served with the accusation.

FAILURE TO MAINTAIN ACTIVE AND CURRENT FNPS NOT ESTABLISHED

30. Complainant did not prove by clear and convincing evidence that Dr. King failed to maintain active and current FNPs for Barstow Women's Medical Clinic and High Desert Women's Memorial Medical Center as required by Business and Professions Code sections 2285 and 2415.

Costs of Enforcement

31. Under Business and Professions Code section 125.3, complainant may request that an administrative law judge "direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case." "A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case." (Bus. & Prof. Code, § 125.3, subd. (c).)

32. The Office of Administrative Hearings has enacted a regulation for use when evaluating an agency's request for costs under Business and Professions Code section 125.3. (Cal. Code Regs., tit. 1, § 1042.) Under the regulation, a cost request must be accompanied by a declaration or certification of costs. For services provided by persons who are not agency employees, the declaration must be executed by the person providing the service and describe the general tasks performed, the time spent on each task, and the hourly rate. In lieu of the declaration, the agency may attach copies of the time and billing records submitted by the service provider. (Cal. Code Regs., tit. 1, § 1042, subd. (b)(2).)

33. Another consideration in determining costs is *Zuckerman v. Board of Chiropractic Examiners* (2002) 29 Cal.4th 32. In *Zuckerman*, the California Supreme Court decided, in part, that in order to determine whether the reasonable costs of investigation and enforcement should be awarded or reduced, the Administrative Law Judge must decide: (a) whether the licensee has been successful at hearing in getting charges dismissed or reduced; (b) the licensee's subjective good faith belief in the merits of his or her position; (c) whether the licensee has raised a colorable challenge

to the proposed discipline; (d) the financial ability of the licensee to pay; and (e) whether the scope of the investigation was appropriate to the alleged misconduct.

Considering the *Zuckerman* factors, the scope of the investigation was appropriate to the allegations and the deputy attorney general who tried the matter was very well prepared. However, complainant's expert mistakenly believed the patient continued to bleed for hours following the C-section, but the records did not support that opinion, nor did the records support the expert's opinion that Dr. King failed to properly evaluate the patient or properly document his treatment. The evidence also did not support the contention that Dr. King violated the laws pertaining to FNPs. Given that none of the charges in the first amended accusation were proven, no costs shall be awarded.

ORDER

The first amended accusation filed against Dr. King is dismissed. No costs are awarded.

DATE: September 26, 2022

Mary Agnes Matyszewski (Sep 26, 2022 09:16 PDT)

MARY AGNES MATYSZEWSKI

Administrative Law Judge

Office of Administrative Hearings